

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

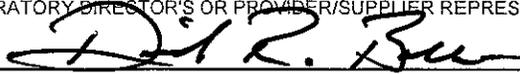
PRINTED: 12/29/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085036	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C. 12/10/2010
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NAME OF PROVIDER OR SUPPLIER FORWOOD MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 1912 MARSH ROAD WILMINGTON, DE 19810
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F 000	INITIAL COMMENTS An unannounced annual survey and complaint visit was conducted at this facility from November 29, 2010 through December 10, 2010. The deficiencies contained in this report are based on observation, interviews and review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was sixty-three (63). The survey sample totaled thirty-one (31) residents.	F 000		
F 223 SS=D	483.13(b), 483.13(b)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. This REQUIREMENT is not met as evidenced by: Based on interviews and review of facility documentation, it was determined that the facility failed to ensure that one (R106) out of 31 sampled residents was free from verbal abuse. Findings include: During interviews with R106 on 11/30/10 at 10:49 AM and 12/9/10 at 9:00AM, R106 stated that he had not been treated with respect and dignity. He stated, "I had problems with the night staff changing my...". He stated that one Certified Nurse Aide (CNA) told him, "You 're all crazy here." R106 stated that he did report it but had not heard anything more. He stated, "They did tell	F 223	F 223 1. R106 has been discharged. Incident was fully investigated and allegation substantiated. Appropriate actions were taken with identified employee in accordance with facility policies & procedures. No negative outcome was identified. 2. All residents have the potential to be affected by this cited practice. 3. All licensed and direct care staff will receive in-service education on Abuse Prevention & Prohibition. 4. Weekly random satisfaction audits/surveys will be conducted by assigned staff x 3 mos. Findings will be submitted to the administrator / designee for appropriate follow-up and corrective action as warranted. Audit results will be reviewed at the QI meeting for compliance.	2/4/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE EXECUTIVE DIRECTOR	(X6) DATE 1/21/11
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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 223	<p>Continued From page 1</p> <p>me that they transferred her (CNA) to another wing." R106 stated that this staff person no longer took care of him.</p> <p>Review of nurse's notes (NN) revealed that R106 was alert and oriented. The NN, dated 11/25/10, recorded "Resident was in his room and was very upset this am (morning) secondary to an incident that occurred over the evening. Family visit cheered resident". No other comments were noted about the incident and what exactly happened to upset the resident.</p> <p>Review of the "Incident Report Form (SNF)", dated 12/7/10 revealed that the allegation of verbal abuse occurred on 11/25/10 at 5:30 AM. E2 (DON) who prepared the report stated in the final outcome the "Employee (sic) verbally abusive to resident-derogatory and rude comments. Employee (sic) terminated". The report noted that R106's wife was contacted on 11/25/10 and the state was notified on 12/2/10. It stated that the incident was substantiated.</p> <p>Review of the "Complaint/Grievance Report Form", dated 11/25/10 at 08:20AM, revealed that R106 stated, "He was called stupid. Resident complains he did not like the way the overnight CNA spoke to him...". The form revealed that E1 (Administrator) and E18 (Social Services Director) became aware of the incident on 12/2/10 and that the allegation was substantiated. It stated that "Follow up to staff member to be completed with staff member per facility policy and procedure".</p> <p>Review of supporting documentation (Investigation Interview Summary) regarding the allegation of verbal abuse of R106 revealed that</p>	F 223		

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F 223 Continued From page 2
staff interviews were conducted on 12/2/10 and 12/3/10 with E21 (3rd shift Nurse), E20 (CNA) and E22 (1st shift Nurse). R106 was interviewed on 12/6/10. Documentation of R106's interview included his statement that, "I had buzzed the buzzer - I'd never seen her before and she said 'what do you want?' and I asked her to get changed. She told me I was stupid - or wasn't acting right. I asked her to speak with her supervisor and she told me she was the supervisor. Then I spoke with another supervisor the next day and she told me she would report it. It just happened so quick I didn't know where she was coming from and then she turned nasty - her whole attitude, the way she talked to me. She just seemed so put out".

F 223

F 225
SS=D The facility failed to protect R106 from verbal abuse. E1 and E4 (Corporate Nurse) acknowledged this finding on 12/9/10.

F 225

483.13(c)(1)(ii)-(iii), (c)(2) - (4)
INVESTIGATE/REPORT
ALLEGATIONS/INDIVIDUALS

The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.

The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and

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F 225	Continued From page 3 misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interviews, review of facility policies and procedures, and facility documentation, it was determined that the facility failed to ensure that one (R106) out of 31 sampled resident's allegation of verbal abuse was immediately reported to the State Agency. Findings include: Cross refer to F223 Review of facility documentation (Investigation Interview Summary and "Complaint/Grievance Report" form) regarding an allegation of verbal abuse by R106 revealed that E33 (CNA) was verbally abusive to the resident. The facility substantiated the allegations of verbal abuse. Documentation revealed that the incident occurred on 11/25/10 at 5:30AM and the facility	F 225	F225 Cross refer to F 223 1. R106 has been discharged. Incident was fully investigated and allegation substantiated. Appropriate actions were taken with identified employee in accordance with facility policies & procedures. No negative outcome was identified. Nursing staff involved were reeducated on the proper guidelines regarding state agency reporting requirements 2. All resident's have the potential to be affected by this cited practice. 3. All licensed and direct care staff will receive in-service education on Abuse Prevention / Prohibition and Reporting requirements. 4. A system for daily review of incident reports will be implemented in order to determine compliance with identified reporting requirements. Monthly Audits will be completed by DON x 3 mos. Findings will be submitted to the administrator / designee for appropriate follow-up and corrective action as warranted. Audit results will be reviewed at the QI meeting for compliance.	2/4/11	

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F 225	Continued From page 4 started the investigation and reported the incident to the State Agency (DLTCRP) on 12/2/10 or seven days later. The facility policy stated the facility was required to report the incident to the State Agency within 24 hours. On 12/9/10 at 3:30 PM, findings were discussed with E1 (Administrator) and E4 (Corporate Nurse). E1 and E4 confirmed that the facility failed to immediately report allegations of verbal abuse to the state agency (DLTCRP). They also failed to thoroughly investigate the incident until 12/2/10. E1 stated that the facility terminated the staff person involved in this incident. The facility failed to immediately report and investigate an allegation of abuse to the state agency. They investigated and reported it 7 days later.	F 225		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility failed to promote care for 1 (R17) out of 31 sampled residents in a manner that maintained or enhanced his dignity. On 12/7/10, R17's urinal was observed with urine in it on top of his bedside cabinet (next to bed) while R17 ate breakfast in bed. The urinal lacked a cap and R17's bedside smelled of urine. Findings include: Review of R17's quarterly minimum data set	F 241	F 241 1. Upon notification R17's urinal was removed and a new one was provided to resident. 2. All residents utilizing urinals have the potential to be affected by this cited practice. 3. All direct care staff will be re-educated on the proper maintenance of urinals. 4. Random room audits by the DON/designee will be conducted during morning meals to ensure compliance. Findings will be submitted to the administrator / designee for appropriate follow-up and corrective action as warranted. Audit results will be reviewed at the QI meeting for compliance.	2/4/11

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F 241	Continued From page 5 assessment, dated 8/23/10, revealed that he was independent in cognitive skills for daily decision-making and dependent on staff for activities of daily living. R17 was non-ambulatory. R17 was observed eating breakfast in bed on 12/7/10. R17's urinal was on the bedside cabinet next to his bed with urine in it. The urinal lacked a cap and R17's bedside smelled of urine. During the survey, there were other observations of urine in R17's urinal attached to the side rail on his bed with urine odors noted as well.	F 241		
F 246 SS=E	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that five (R1, R17, R72, R77 and R158) out of 31 sampled residents did not have a call bell placed within reach to call for assistance. Findings include: 1. R72 was observed on 11/30/10 at 8:50 AM seated on the left side of her bed in a geri chair. R72's call bell was observed lying on the floor on the right side of the bed.	F 246		

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F 246	Continued From page 6 In an interview with E9 (CNA) on 11/30/10 at approximately 9:00 AM, she stated that R72 was capable of pressing the call bell for assistance. E9 picked up the call bell and placed it within R72's reach.	F 246	F 246 1. R158 is no longer in the facility. R1, R17, R72, R77 will be re-evaluated for ability to use call bells and plan of care will be revised in order to meet their needs as required.	2/4/11	
	2. R158 was observed on 11/30/10 at 1:30 PM seated in a wheelchair on the right side of her bed. The call bell was lying on the floor on the left side of the bed out of the resident's reach. 3. R77 was observed on 12/2/10 at approximately 8:30 AM, seated in a wheelchair near the foot of her bed on the left side. The resident's call bell was found hanging behind the bed's headboard out of the resident's reach. E7 (nurse) observed the placement of the call bell with the surveyor. 4. R17 was observed on 11/30/10 at approximately 11:30 AM lying on his bed and his call bell was not accessible and not visible. The surveyor asked the resident to press the call bell to test it and the resident could not locate or reach the call bell. E24 (Maintenance Director) then proceeded to help the resident locate the call bell which was found tied to the left side of the bed out of the resident's reach. E24 confirmed that it was a problem. On 11/30/10 at 12:00 PM, R17 was observed sitting in his wheel chair in his room and had no call bell near by. Staff interview with E25 (Nurse) confirmed that the resident could use his call bell. 5. R1 was observed on 11/30/2010 at 9:18 AM lying on her bed. The call bell was lying on the floor by the foot board of the bed out of resident's reach. E25 (Nurse) stated that the resident could use the call bell.		2. All residents have the potential to be affected by this cited practice. 3. All direct care staff will receive in-service education regarding proper call bell placement requirements in order to ensure residents' needs are met. All current residents and new admissions will be assessed for use of call bell and appropriate interventions will be implemented in order to assure resident's needs are met. 4. Random room audits of 10% of the resident population by the DON/designee will be conducted to ensure compliance. Findings will be submitted to the administrator / designee for appropriate follow-up and corrective action as warranted. Audit results will be reviewed at the QI meeting for compliance.		

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F 253 SS=E	<p>483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations throughout the survey, and staff interview, it was determined that the facility failed to provide maintenance and housekeeping services necessary to maintain an orderly and sanitary interior. Findings include:</p> <p>1. Observations of the facility hallways in the Elm, Aspen, and Birch wings on 11/30/10 through 12/10/10 revealed the rugs to be stained. Interview with E24 (Maintenance Director) confirmed that the rugs were stained and could not be cleaned anymore. He stated that the rugs had reached the end of their life span.</p> <p>2. An offensive odor was detected in four resident bathrooms or bedrooms on 11/30/10 and 12/6/10: 102B (11:15 AM on 12/6/10), 103B (11:15 AM on 12/6/10), 113A (10:43 AM on 12/6/10), 137A (11:00 AM on 11/30/10 and 12:05 PM on 12/6/10).</p> <p>3. The top drawer of residents' night stands for resident rooms: 120A, 134, 137A, and 145 were in disrepair (could not be closed).</p> <p>4. Observations of resident rooms 102A, 111, 114B, and 145 during the environmental tour on 12/6/10 with E24 and E26 (Housekeeping Supervisor) revealed a gap between the bed frame and the mattress greater than four inches</p>	F 253	<p>F 253</p> <ol style="list-style-type: none"> 1. Identified carpet areas will continue to be maintained on a regular cleaning schedule. Carpet will be assessed for replacement. Vendor/contractor has been identified and carpet samples were obtained 1/10/11 in order to identify carpet choice for future replacement. Upon notification by surveyor rooms were re-inspected and the source of offensive odors for rooms were identified. Housekeeping procedures were conducted to eliminate odors. Identified night stands & mattresses have been repaired/replaced. Mattress fillers were ordered and will be utilized as needed for gaps. The identified Hoyer lift was cleaned following notification by the surveyor. 2. All residents have the potential to be affected by this cited practice. 3. During survey, room rounds were completed on all resident rooms to assess appropriate spacing between bed mattresses & frames as well as condition of furniture. All items identified to be in disrepair were replaced/repared. Any identified issues were immediately addressed and mattresses replaced to comply w/ required spacing <p>All nursing staff will be inserviced regarding the proper handling/removal of trash from resident care areas.</p>	2/4/11

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F 253 Continued From page 8
(about four to six inches). Interview with E24 revealed that the positioning bars, that should have kept the mattress from moving, were not placed in the upright position to prevent the mattress from sliding. E24 also stated that R106's bed frame was installed incorrectly. An interview with E24 on 12/7/10 at 10:30 AM revealed the bed frame was repaired.

5. Observations made during the environmental tour on 12/6/10 at 11:00 AM revealed bags of trash on the top of the linen carts in the bathrooms of rooms 104 and 108. On 12/9/10 at approximately 8:15 AM, bags of trash were observed on the floor of resident rooms 111 and 145.

6. The Hoyer lift stored inside the Elm common shower bathroom was observed soiled on 12/6/10 at 10:30AM. Staff interview with E26 acknowledged this finding.

F 272 483.20, 483.20(b) COMPREHENSIVE
SS=D ASSESSMENTS

The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.

A facility must make a comprehensive assessment of a resident's needs, using the 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;

F 253 4. Weekly rounds will be conducted by Environmental Services Supervisor/Designee to ensure orderly structure and sanitation of resident rooms. Random monthly audits will be made by NHA/designee to ensure compliance required environmental standards for sanitation and housekeeping. Findings will be reviewed in monthly QI meeting x3 and quarterly thereafter with corrective action as warranted.

F 272

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F 272 Continued From page 9
 Psychosocial well-being;
 Physical functioning and structural problems;
 Contenance;
 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 through the resident assessment protocols; and
 Documentation of participation in assessment.

This REQUIREMENT is not met as evidenced by:
 Based upon observation, interview and record review the facility failed to accurately complete a comprehensive assessment for one (R12) out of 31 sampled residents. R12's annual Minimum Data Set (MDS) assessment, dated 1/15/10, related to Range of Motion (ROM) was incorrectly coded. Findings include:

On 12/6/10, an observation was made of R12. E13 (CNA) dressed the resident by placing the sleeves of a shirt on R12's arms due to the limitation in abduction of shoulders and extension of elbow and then stretching, lifting the shirt over R12's head due to the limited ROM of her neck.

Review of the Physical Therapy (PT) ROM Assessment, dated 6/27/09, revealed that R12 was severely limited in neck rotation and neck midline positioning. Additionally, R12 was limited in right and left shoulder abduction, limited on the right elbow extension and severely limited on the

F 272 F 272 2/4/11

1. R12 MDS was corrected on 12/7/10 to accurately reflect ROM status.
2. All residents have the potential to be affected by this cited deficient practice.
3. All current MDS's will be reviewed to show accurate coding of ROM status and corrections will be made as needed and will be submitted for transmission. The MDS coordinator will coordinate with Therapy to assure their ROM screening schedule coincides with the MDS schedule to assure accurate coding of the MDS for ROM. The MDS coordinator/designee will review the MDS prior to submission to assure that the therapy screen data matches the appropriate code on the MDS.
4. The DON/ designee will review a random sample of six (6) MDS assessments monthly prior to a final submission to assure accuracy of coding x 3 mos. Any errors identified will be immediately corrected.

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F 272	Continued From page 10 left elbow extension. Review of the quarterly Interdisciplinary Rehabilitation Screening Form, dated 1/21/09, revealed that R12 had "Limit or problem" in "Bed Mobility; Transfers; Gait; Balance; ADL: Feeding, Bathing, Dressing, and Toileting and Positioning". The screening summary was checked that R12 had, "No change". The annual MDS, 1/15/10, incorrectly coded R12's ROM as no limitation/no loss of voluntary movement in her neck and limitation on one side of her arm including shoulder or elbow. However, the PT ROM Assessment and Screening Form did not support the coding. On 12/7/10 in an interview, E8 (LPN MDS Coordinator) confirmed the findings and stated that she would make the corrections.	F 272			
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)	F 274			

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F 274	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to complete a significant change Minimum Data Set (MDS) assessment for one (R46) out of 31 sampled residents. Findings include: R46's clinical record revealed that she had been admitted to hospice services on 10/12/10. Review of the clinical record lacked evidence that a significant change assessment had been completed when the resident elected to receive hospice benefits. During an interview with E8 (MDS Coordinator) on 12/8/10 at 10:45 AM, E8 stated that she was aware that a significant change assessment should have been completed when a resident elects hospice benefits. E8 acknowledged that one had not been completed for R46 and stated that she would begin working on it.	F 274	F 274 1. R46 had a significant change MDS completed on 12/8 and transmitted to state data base prior to survey exit. 2. All residents admitted to hospice services have the potential to be affected by this cited practice. 3. An MDS audit was completed on all residents that are currently on hospice services to ensure that a significant change MDS had been completed. Residents that required a significant change MDS have had one completed and placed in their file. A protocol has been established to assure that the MDS Coordinator is notified timely of residents that are admitted/discharged from hospice services. 4. A random monthly audit of all residents placed on, or discharged, from hospice will be completed by DON/nurse designee to assure compliance. Findings will be corrected as warranted.	2/4/11
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.	F 278		

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F 278	<p>Continued From page 12</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interviews, it was determined that the MDS (Minimum Data Set) assessment for 2 (R118 and R12) of 31 sampled residents, failed to accurately reflect the resident's status. Findings include:</p> <ol style="list-style-type: none"> 1. Review of R118's clinical record indicated that she was receiving Hospice services. Review of R118's Quarterly MDS 3.0, dated 11/10/10, revealed that the facility failed to code R118 as continuing to receive "Hospice" services. <p>Findings were confirmed with E8 (MDS Coordinator) during an interview on 12/8/10 at 11:20 AM and MDS corrections were subsequently completed.</p> <p>Cross refer to F272</p> <ol style="list-style-type: none"> 2. On 12/8/10, an observation was made of R12 being dressed. <p>Review of the Physical Therapy (PT) ROM</p>	F 278	<p>F 278 Cross refer to F 272</p> <ol style="list-style-type: none"> 1. R 18 & R 112 – A corrected MDS assessment was completed and transmitted for R 118 on 12/8/10 and R 12 on 12/7/10 prior to exit. 2. All residents have the potential to be affected by this cited practice. A protocol has been implemented to communicate completion of quarterly therapy screens to assure data is reviewed by MDS Coordinator timely during the assessment period and is coded accurately. 3. An MDS audit was completed on all residents that are currently on hospice services to ensure that a significant change MDS had been completed. Residents that required a significant change MDS have had one completed and placed in their file. A protocol has been established to assure that the MDS Coordinator is notified timely of residents that are admitted/discharged from hospice services. 4. A random MDS assessment audit will be completed on 10% of the facility's resident population monthly to assure accurate coding of the MDS and findings will be corrected as warranted. 	2/4/11

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F 278	Continued From page 13 Assessment, dated 6/10/10, revealed that R12 was severely limited in her neck rotation and neck midline positioning as well as right and left shoulder abduction and right and left elbow extension. The quarterly Minimum Data Set (MDS) Assessments, dated 6/27/10 and 9/13/10, incorrectly coded R12's ROM as no limitation/no loss of voluntary movement in her neck and limitation on one side of her arm including shoulder or elbow. However, the observation and the PT ROM Assessment did not support the coding. On 12/7/10 in an interview, E8 (LPN MDS Coordinator) confirmed the findings and stated that she would make the corrections.	F 278			
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of other documents as indicated 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	F 309			

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F 309	<p>Continued From page 14</p> <p>for 4 (R46, R72, R95 and R118) out of 31 sampled residents. The facility failed to ensure that R118 no longer received the medication, Aricept after the order was discontinued on 6/21/10. The facility failed to ensure the use of R46's arm trough (positioning device) per the plan of care and failed to follow therapy's recommendations for seating for R72. The facility failed to follow physician's orders for the administration of acidophilus for R95. Findings include:</p> <p>1. R46 was re-admitted to the facility from the hospital on 5/8/09. Diagnoses included hypertension, dementia and cerebrovascular accident (CVA - stroke) with left sided paralysis. The 9/15/10 quarterly Minimum Data Set (MDS) assessment stated that R46 was totally dependent on facility staff for activities of daily living (ADLs).</p> <p>A "Physical Therapy Plan of Treatment for Rehabilitation," service dates 5/12/09 to 6/8/09, stated, "(Left) arm trough for safety and positioning." A physician's order, dated 5/12/09 stated the resident was to use a left arm trough (device attached to a wheelchair armrest) for safety and positioning.</p> <p>A care plan entitled, "Self care deficit related to (decreased) mobility (secondary) CVA" included the approach, dated 11/2/09, "(left) arm trough, posterior tilted w/seat for safety and positioning." Another care plan, dated 10/13/10, and entitled, "Pain related to (left) arm pain" included the approaches, "Position device left hand splint + trough for pain relief..."</p> <p>Review of the treatment administration records</p>	F 309	<p>F 309</p> <p>1. R118 – Physician orders and MAR have been properly recapitulated and is no longer receiving the medication - Aricept. R118 remains in the facility without and negative effect from the cited practice. R46 was re-evaluated by Therapy on 12/3 and was skilled through 1/3/11 for wheelchair seating/positioning and caregiver education. Resident is no longer utilizing the arm trough as per therapy recommendations. Positioning improved with wheelchair seating/positioning techniques. The plan of care has been revised to meet current resident care needs and caregiver education completed. R46 remains in facility and has had no negative outcome from the cited practice. R72 was re-evaluated by Therapy for seating/ positioning and is currently on therapy caseload for the same. Caregiver education is being provided at this time. R95 remains in the facility and is no longer on the medication PB 8. Medication PB8 was discontinued prior to survey exit. R 95 has had no negative effect from the multiple doses noted from the cited practice.</p> <p>2. All residents have the potential to be affected by this cited practice.</p>	2/4/11

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F 309	<p>Continued From page 15</p> <p>(TAR) lacked documented evidence that the arm trough was utilized for positioning in 6/10, 7/10 and 9/10 through 11/10.</p> <p>Observations were made of R46 as follows: 11/30/10 10:05 AM - Seated in wheelchair (w/c), left arm not positioned on trough; 12/1/10 11:15 AM - Seated in w/c, left arm not positioned on trough; 12/3/10 2:00 PM - Seated in w/c, left arm not positioned on trough, leaning to left; 12/6/10 8:27 AM - Seated in w/c, arm not positioned on trough; 12/6/10 9:50 AM - Seated in w/c at activity in lounge, left arm not positioned on trough, leaning to left with upper left back against armrest/trough; 12/6/10 11:45 AM - Left arm not positioned on trough, leaning against it; 12/6/10 12:15 PM - Resident was in dining area, left arm not placed on trough for positioning, leaning to left against trough.</p> <p>On 12/6/10 at approximately 12:15 PM, E16 (Physical Therapist) when interviewed stated that the device on R46's w/c armrest was "probably for positioning of the left upper extremity."</p> <p>A "Rehab Plan of Treatment," certification date 12/3/10 to 12/17/10, stated "(Patient) was evaluated sitting in w/c in therapy department...observed to have lateral lean to (left), sacral sitting, arm tray (left) side...would also benefit from proper w/c positioning for skin integrity, safety, comfort..."</p> <p>The facility failed to follow R46's plan of care for positioning.</p> <p>2. R72 was admitted to the facility on 12/2/09 with</p>	F 309	<p>3. All licensed staff will be provided re-education and be assessed for competency on recapitulation orders and the 24 hour chart check process with emphasis placed on the accuracy of orders. All residents readmitted to the facility will have transfer medications orders reconciled to prior medication orders within 24 hours of readmit by the Unit Manager/Nurse Designee. Any discrepancy in orders with regard to medication administration times, and dosage will be clarified with the physician. Nursing will also fax to Pharmacy the original transfer orders for review to ensure accurate reconciliation and transcription of orders has been completed. All errors identified will be corrected. License staff will also be provided in-service education on reconciling of medication</p> <p>4. Daily observations will be made for 1 month by the DON/designee on all residents with orders for seating and use of orthotic devices to assure compliance. Thereafter, observations will be conducted weekly x 1 month and thereafter monthly x 3 mos. A monthly random audit of 10 % of the resident population will be completed to ensure that each resident's MAR and Physician order sheets and have been recapitulated and reconciled accurately. Findings will be corrected as warranted and reviewed in the quarterly QI meeting.</p>	

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diagnoses that included dementia, osteoporosis, and depression. The 12/3/10 quarterly Minimum Data Set (MDS) assessment stated that R72 was totally dependent on facility staff for all activities of daily living. This MDS also stated under "Makes Self Understood" and "Ability to Understand Others" that the resident "Sometimes understands-responds adequately to simple, direct communication only."

A care plan entitled "Self care deficit," reviewed on 7/2/10 included the approach, "OOB (out of bed) to geri recliner." On 8/13/10, the approach "Geri recliner (up) for 2 hrs @ a time when in reclined position" was added. On 8/18/10 the approach was again revised to state "OOB to geri recliner ad lib (as desired)."

A Rehabilitative Services Progress Note, dated 7/16/10 stated, "Patient seen at lunchtime (after) just getting up to geri-chair...Posture reassessed + due to...thoracic kyphosis (a C curvature in the thoracic spine) unable to improve current sitting posture (with) cushion or other external supports. Would recommend frequent checks for repositioning (approximately 30 minutes)...Also would recommend only short periods of sitting (due to) quickly fatiguing (approximately 1-2 hours, 2-3x/day). Recline for safety as needed..."

The following observations were made of R72:
11/30/10 8:50 AM - Was in geri chair sleeping in room;
11/30/10 11 AM - Remained seated in geri chair with pillow on right side sleeping;
11/30/10 12 PM - Remained seated in geri chair now slumped down sideways with head between pillow and back of chair. Trying to shift her weight and grimacing, moving left leg and hanging it over

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the right armrest. Resident is shifting her bottom downward and bringing legs over the side to hang off the geri chair;
11/30/10 12:10 PM - 2 staff pulled resident up and repositioned in geri chair;
11/30/10 1:25 PM - Remained seated in geri chair with pillow behind back;
11/30/10 2:45 PM - Remained as above;
11/30/10 4 PM - Remained seated in geri chair but has been repositioned upwards in the chair;
12/6/10 11:30 AM - Seated in geri chair in room;
12/6/10 11:55 AM - Being pushed out to lounge area in geri chair;
12/6/10 12:20 PM - In restorative dining area being fed ice cream and applesauce by E6 (nurse);
12/6/10 3 PM - Sitting in geri chair, slumped down, right shoulder pressed against armrest;
12/7/10 11 AM - Seated in geri chair in room, slumped down in chair, lying on lower back with pillow behind head; shifting both legs off of leg rest portion and at one point lifted one leg onto the tray table which is next to her.

On 12/6/10 at 11:30 AM while R72 was seated in a geri chair in her room, E6 was interviewed regarding a blue plastic like substance the resident was sitting on. E6 stated the substance was Dycem (provides a non-slip surface and increased friction), "because she scoots down."

On 12/10/10 at 9:30 AM, E6 was interviewed regarding therapy's recommendation for having the resident seated only for 2-3 hrs 2-3x/day and being placed to bed for rest periods. E6 stated that she remembers writing the order for "OOB to geri chair ad lib" and thinks she remembers that the resident's son told them that he "didn't want his mother in bed all the time." E6 stated she

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would go and look for documentation of the above conversation with R72's son. On 12/10/10 at 11:35 AM, E18 (Social Worker) informed the surveyor that E6 was unable to locate any documentation of a conversation with R72's son regarding her sitting in the geri chair. There was no documented evidence that the facility had reviewed PT's recommendations for seating with this family member.

Although the facility attempted to reposition R72 regularly while she was seated in a geri chair, they failed to follow therapy's recommendations. The facility failed to provide the care and services to attain or maintain R72's highest practicable well-being.

3. R95 had a physician's order, dated 7/29/10 for "PB8 (acidophilus - contains probiotic strains found to increase the production of healthy bacteria and inhibit that of harmful varieties in the gastrointestinal tract) 2 caps (capsules) daily for the duration of ABT (antibiotic) therapy."

Review of the medication administration records (MAR) revealed that from 10/1/10 through 11/18/10 and 11/25/10 through 12/7/10, R95 did not receive any antibiotics. The facility continued to administer the acidophilus during this time frame, despite the order to administer only during antibiotic therapy.

Findings were acknowledged by E1 (Administrator) and E4 (Corporate Nurse) on 12/9/10 during an interview.

4. The facility policy entitled "Medication and

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Treatment Order Guidelines, dated 3/4/04, stated, "... Discontinue an order by writing "D/C" across the section on the MAR..., including initials and date. Also write "D/C" next to the order on the Physician's Order Sheet... The appropriate nurse is notified and the medication removed from the medication cart...".

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Review of R118's clinical record revealed a physician's order, dated 5/25/10, for Aricept 5 milligrams orally at bedtime (a medication used to treat mild to moderate dementia). On 6/21/10 an order was written to "D/C (Discontinue) Aricept."

R118's monthly POS (Physician's Order Sheet) from 6/10 through 12/10 incorrectly continued to carry this order each month. All months except 8/10 and 9/10 POSs had handwritten documentation that this order was discontinued on 6/21/10.

Review of R118's monthly MARs (Medication Administration Records) revealed that the Aricept order incorrectly continued to be carried over onto each month's MAR. Review of the 7/10 MAR indicated that R118 had received a dose of Aricept on 7/1/10 and 7/2/10 even though it had already been discontinued.

The 8/10 MAR indicated that on 8/2/10 and 8/7/10 (2 of 11 days documented), Aricept was administered to R118. The other nine days, circled initials indicated that it was not administered. On the back of the MAR, there was documentation that on 8/10/10 at 9:00 PM, the medication was "Unavailable - ... notified - Asked to call pharmacy again b/c (because) med (medication) is so expensive & not seen." R118's Aricept order on the 8/10 MAR remained

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as an active order until 8/11/10, when "Order D/C'd" was then handwritten on the MAR.

Review of R118's 9/10 POS again listed the Aricept order. It again was listed on the 9/10 MAR and was signed as administered on 9/1/10 then, marked as "DC". Both the 10/10 and 11/10 POSs and MARs listed Aricept with handwritten notes that read, "D/C 6/21".

On 11/28/10, another physician's order read, "Hospice recommendations: Discontinue Aricept 5 mg po @ HS." The physician documented on the same order sheet, "Agree D/C Aricept." However, once again the 12/10 POS listed the Aricept order with the handwritten note "D/C 6/21".

Review of the 12/10 MAR indicated that R118 received 1 dose of Aricept on 12/1/10 and then signed off on 12/2/10 as not administered with another handwritten note, "D/C'd 6/21/10.

The facility failed to follow a physician's order, dated 6/21/10, to discontinue R118's "Aricept" medication and it continued to appear on both the monthly POSs and the MARs for six months. Subsequently, R118 received unordered doses of Aricept in July, August and December (5 doses total) despite the medication being discontinued twice and 24 hr chart checks signed as completed.

During an interview on 12/10/10 at 10:10 AM, E2 (DON) acknowledged these findings and stated that the facility was scheduled to meet with the pharmacy on that day and would discuss this problem.

F 315 483.25(d) NO CATHETER, PREVENT UTI, F 315

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F 315 Continued From page 21
SS=D RESTORE BLADDER

F 315 F 315

2/4/11

Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

This REQUIREMENT is not met as evidenced by:

Based on record review, review of facility documents and staff interviews, the facility failed to ensure that a resident who was incontinent of bladder received appropriate treatment and services to restore as much normal bladder function as possible for one (R29) out of 31 residents sampled. The facility failed to follow their procedures for the management of bladder incontinence. Findings include:

Review of the facility policy entitled, "Bladder Incontinence Interventions" stated, "... If it is determined that the resident is incontinent an in-depth assessment will be completed using the Bladder Incontinence Assessment form... A 3-Day Bowel and Bladder Flow Sheet... will be completed on each incontinent resident. Utilizing the Assessment Form and the Flow Sheet, the recommendation will be made for placement into the appropriate bladder program. The resident will be re-assessed if there is a significant change in status and annually... A bladder program consists of four major interventions: Bladder

1. R 29 will have a 3 day bowel & bladder assessment completed to assess residents voiding pattern to assure the appropriate toileting interventions are in place in order to meet resident care needs.
2. All residents with bladder incontinence have the potential to be affected by this cited practice.
3. All licensed staff will be provided in-service education on facility's policy & procedure re: bladder incontinence interventions and bladder retraining program. All current residents identified with incontinence will have a chart audit completed to ensure the three day bladder assessment has been thoroughly completed with appropriate toileting interventions completed.
4. Random audits will be completed on 10% of incontinent residents to ensure accurate completion of bowel & bladder assessments and that appropriate interventions are in place. Audits will be conducted by DON/designee monthly x three (3) months. Findings will be corrected as warranted.

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F 315	<p>Continued From page 22</p> <p>retraining, Habit training/scheduled toileting, Prompted voiding, and, Self-catheterization...".</p> <p>R29 was admitted to the facility on 6/25/07 with diagnoses that included diabetes, hypertension, cardiovascular disease and anemia. Review of R29's clinical record revealed that R29 had a history of UTI's (urinary tract infections), was on a 1000 cc fluid restriction and her medications included a daily diuretic (fluid pill).</p> <p>Both R29's Annual MDS (Minimum Data Set) Assessment, dated 4/14/10, and the Quarterly MDS Assessment, dated 9/21/10, indicated that the resident had short term memory problems, but was "independent" in her cognitive skills for daily decision making. The assessments indicated that R29 was incontinent of bowel and bladder, she was totally dependent for toileting and required 2+ persons physical assistance. R29 was not on a scheduled toileting plan.</p> <p>Review of R29's "Annual" Bladder Incontinence Assessment, dated 4/15/10, was incomplete. The summary stated, "After review of the Bladder Incontinence Assessment and the 3 Day Bowel and Bladder Flow Sheet the resident: (box checked) IS NOT Recommended for Retraining Program." The reason listed was "patient incontinent." The facility was unable to provide evidence that a 3-Day Bowel and Bladder Flow Sheet was completed.</p> <p>R29's most recent Bladder Incontinence Assessment, dated 9/18/10, was also incomplete. The facility failed to indicate R29's type of incontinence. The assessment indicated that R29 had a "Diminished" perception of the need to void and experienced "daily incontinence</p>	F 315		

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F 315 Continued From page 23

episodes (some control)". The assessment indicated that R29 had "No apparent pattern" for voiding, yet review of R29's clinical record lacked evidence that a 3-Day Bowel and Bladder Flow Sheet (voiding diary) was completed. Additionally, the facility failed to indicate why the assessment was done, ie., "Admission", "Significant Change", "Annual" or "Other".

During an interview on 12/10/10, E17 (Certified Nurse Assistant) confirmed that R29 was incontinent of bladder daily and was toileted using a "stand aide lift" with 2 person assist. E17 stated that she had never completed a 3-Day voiding diary for R29. She stated that R29 was able to tell staff when she needed to be toileted.

Review of R29's care plan entitled, "Alteration in elimination related to incont (incontinence) bowel and bladder", was initiated on 6/26/07 and last reviewed on 11/30/10. The following approaches were discontinued: "1. Assist with toileting as resident is able. 2. Encourage highest level of participation in toileting." Approach # 3 was changed from "Incontinence care q (every) two hours and prn (as needed)" to "Incontinence care each round and prn." Other active approaches included, "4. Absorbent products prn. 5. Bowel and Bladder assessment..."

Findings were confirmed with E2 (Director of Nursing) during an interview on 12/10/10.

The facility failed to complete an in-depth bladder incontinence assessment, including a 3-Day Bowel and Bladder Flow Sheet (voiding diary) and failed to use the data to recommend placement into an appropriate bladder program as per their policy. Since the facility failed to determine R29's

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F 315 Continued From page 24
voiding pattern, the care plan lacked resident specific interventions related to her toileting schedule. Consequently, the facility failed to ensure that R29 who was incontinent of bladder received appropriate treatment and services to restore as much normal bladder function as possible.

F 315

F 318 483.25(e)(2) INCREASE/PREVENT DECREASE
SS=D IN RANGE OF MOTION

F 318 F 318

2/4/11

Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.

1. R 46 was evaluated by occupational therapy on 12/1/10 for the use of the hand splint. Resident has new order guidelines for hand splint application. Caregiver education has been provided.
2. All residents with the need for orthotic devices/splint have the potential to be affected by this cited practice.
3. All licensed staff will be inserviced on proper documentation guidelines for TAR orders. All residents utilizing hand splints/orthotic devices will be assessed for proper use of splints and caregiver education will be provided as needed.
4. Daily observations will be made for 1 month by the DON/designee on all residents with orders for splint/orthotic devices to assure compliance scheduled application and documentation on TAR's. Thereafter, observations will be conducted weekly x 1 month and monthly x 3 mos. respectively. Findings will be reported to QA committee with a corrective action plan as warranted.

This REQUIREMENT is not met as evidenced by:
Based on observation, record review and interview, it was determined that the facility failed to ensure that one (R46) out of 31 sampled residents, received appropriate treatment and services to increase range of motion (ROM) and/or to prevent further decrease in range of motion. Findings include:

R46 was re-admitted to the facility from the hospital on 5/8/09. Diagnoses included hypertension, dementia and cerebrovascular accident (CVA - stroke) with left sided paralysis. Minimum Data Set (MDS) assessments from 5/15/09 through 9/15/10 indicated that R46 had a limitation in ROM and full loss of voluntary movement of the arm, hand, leg and foot on one side.

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Physician's orders, dated 6/9/09, stated that R46 was to wear a left hand splint/palmer for 5 to 10 hours at a time when up in the morning and when ready for bed at night.

A care plan entitled "Self care deficit related to (decreased) mobility (secondary to) CVA," last reviewed on 9/17/10, included the approaches, "Wash cloth in left hand to prevent skin breakdown (secondary to) contracture and frequently refusing brace...(left) hand/palmer protective wearing schedule for 5-10 hours at a time as resident will allow in AM + when ready for bed at night."

Review of treatment administration records (TARs) revealed a lack of signatures indicating that the splint was not applied from 1/10 through 3/10, and 6/10 through 11/10. Additionally, there was no documentation on the TARs that the resident was refusing to wear the splint. Review of nurse's notes from 9/09 through 11/30/10 lacked evidence that R46 was refusing to wear the splint.

A "Care Plan Conference Summary," dated 9/29/10, stated "Washcloth in (left) hand/CNA (certified nurses aide) need to cut fingernails. OT (Occupational Therapy) eval (evaluation) for contracture." A nurse's note, dated 9/29/10 and timed 11:30 AM, stated "...resident is (complaining) that she doesn't want to wear brace on (left) arm...and would like a washcloth placed in hand to prevent skin breakdown..." Review of physician's orders revealed that an order was never written for an OT evaluation as per the care plan summary.

Multiple observations of R46 on 11/30/10 and on

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the morning of 12/1/10 revealed that the resident did not have a splint or a rolled washcloth in place in her left hand. During an interview with E12 (nurse) on 12/1/10 at 11:45 AM, E12 stated that R46 had a left hand contracture and a splint was used. However, upon review of the 11/10 TAR, E12 acknowledged the lack of signatures signifying application of the splint.

On 12/2/10 and 12/3/10, R46 was observed wearing a splint on her left hand.

On 12/3/10 at 3:30 PM during an interview with E4 (corporate nurse), she acknowledged the lack of documented evidence of the splint having been consistently applied. E4 stated that she fed R46 her lunch on 11/29/10 and also did not see a splint on her left hand.

Review of physician's orders, dated 12/1/10, revealed an order for an OT evaluation for use of the hand splint. During an interview with E5 (Director of Rehabilitative Services) on 12/6/10, she stated that R46 was being evaluated by therapy.

On 12/6/10 at 3:10 PM, R46 was observed having her left hand massaged and soaked in warm water by E5 and E10 (CNA). R46 tolerated the procedure well and denied any pain. Observation of the left hand revealed that the skin of the palm was intact, however the fingernails were elongated and in need of trimming. E10 acknowledged that the nails needed to be trimmed and E5 stated that an aide had already been informed.

In an interview with E10 on 12/6/10 at approximately 3:20 PM, she stated that she had

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not seen the R46 wearing a splint "in awhile" or noticed a rolled washcloth in her hand either.

On 12/7/10 at 2:50 PM, E11 was interviewed. E11 stated that she had not seen the splint used except for the past few days. When asked if she was aware that the resident was supposed to have a splint, she stated no.

A "Rehab Plan of Treatment," certification date 12/3/10 to 12/17/10 stated, "Pt (Patient) was evaluated sitting in w/c in therapy department...Clinical Impression/Assessment: Pt would benefit from skilled OT services for orthotic management/training (secondary) pt has been inconsistently wearing orthosis (splint)..."

The facility failed to ensure that R46, who had a limited range of motion, received treatment and services to increase range of motion and/or to prevent further decrease in range of motion. The facility failed to consistently apply R46's splint on her left hand.

F 318

F 329 SS=E 483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS

Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.

Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not

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F 329	<p>Continued From page 28</p> <p>given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based upon record review and interview, the facility failed to ensure that each resident's drug regimen was free from unnecessary drugs for 5 (R12, R38, R80, R95 and R106) out of 31 sampled residents. Findings include:</p> <p>The facility policy entitled, "Psychopharmacological Medication" was reviewed.</p> <p>1. R38 was a 99 year old long term resident with multiple diagnoses including cardiovascular disease and congestive heart failure.</p> <p>Review of R38's clinical record revealed that she received multiple medications for the treatment of insomnia, in addition to Xanax for the treatment of anxiety.</p> <p>Review of R38's physician's orders revealed that she received the following medications for insomnia: Trazadone, 25 mg nightly, since 4/15/09 Ambien, 12.5 mg nightly, which was increased</p>	F 329		

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from 10 mg on 2/25/10. The manufacturer's (Sanofi-Aventis) recommended dose for elderly patients is 5 mg once daily and it is indicated for short-term use.
Sonata, 10 mg as needed nightly since 4/3/10. The manufacturer's (King Pharmaceuticals) recommendations indicates the medication is for short-term use.
Additionally, R38 had an order, dated 4/15/10, for Xanax 0.25 mg every 6 hours as needed for anxiety.
R38's prn (as needed) medications were reviewed for 11/10. The Sonata controlled drug sign-out sheet revealed that she received the medication on 21 out of 30 days with only three days showing an indication for use (insomnia) on her Behavior/Intervention Monthly Flow Record. The Xanax controlled drug sign-out sheet revealed that she received the medication on 29 out of 30 days, always coinciding with the administration of the Sonata. No indication for its use was found in the clinical record. Additionally, there was no evidence that monitoring of effectiveness was completed for either the Sonata or Xanax.
A Pharmacist/Physician Communication sheet, dated 3/30/10, stated, "Observation/Comment: Resident has received an order to increase Ambien 10 (to) 12.5mg at bedtime and is also receiving trazadone 25mg nightly at bedtime. Recommendation: Please consider attempting a GDR (gradual dose reduction) to discontinue the order for trazadone due to the increased dose of Ambien. If appropriate for this resident, please document benefit vs risk of continuing at the current dose." The physician's response stated

F 329

F 329

2/4/11

1. **R 38** remains in the facility. A medication review was completed with the Medical Director of resident's order for Sonata, Xanax, and Ambien. The Medical Director had a verbal conversation with the resident's attending physician to importance of gradual drug reduction and for providing clinical rational for duplicative drug therapy on 1/20/11. The facility psychiatrist has been consulted to review resident's current drug regimen for sleep. **R106** was discharge from the facility. **R95** remains in the facility and has had no negative outcome from cited practice. **R12** remains in the facility and a CBC and BMP was completed on 12/16/10 and reviewed by the physician with no new orders recommended. **R80** was discharged from the facility on 1/2/11. Medications were reviewed with physician on 12/8 and an ordered was written that physician wanted resident to remain on both medications identified despite pharmacy recommendations. **R106** was discharged from the facility on 12/13/10 with AIMS completed 12/10/10 with no issues identified.
2. All residents have the potential to be affected by this cited practice.

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that he did not want to implement any changes because "She (R38) still says she doesn't sleep well."

A nurse's note, dated 9/24/10, stated, "...Resident receives multiple medications for insomnia and states she still has difficulty sleeping..."

During an interview with R38 on 12/8/10, she stated that she had been on medications to help her sleep for a long time. She stated that they give her one kind of medication before bedtime, then give her another kind when she awakens around midnight.

A psychiatric consult for R38, dated 10/26/10, listed: Trazadone and Ambien for sleep and Xanax for anxiety. It did not mention the Sonata. The psychiatrist wrote, "...Pt (patient) wants her meds. She doesn't wish them to be d/c'd (discontinued)."

During an interview with E2 (Director of Nursing), on 12/7/10, she stated that the facility had medication reduction meetings quarterly with each physician. However, during interviews with E18 (Social Worker) on 12/7/10 and E8 (MDS Coordinator) on 12/8/10, it was revealed that R38's physician refused to attend medication reduction meetings at the facility unless he had at least 10 residents residing there.

There was no evidence in R38's clinical record that a medication review was conducted or a gradual dose reduction was attempted for her psychotropic drugs since 2/23/09. The clinical record lacked documented rationale for the prolonged use of multiple medications used to treat R38's insomnia.

F 329

3. All licensed staff will be inserviced on proper documentation guidelines for administration of antipsychotic medications in accordance with facility policies & procedures. Monthly medication reduction meetings will be structured to include all residents with recommendations to attending physicians.

4. DON/designee to review and follow up as necessary from monthly pharmacy review and medication reduction review committee. Findings to be reported monthly x 3 mos. to QA committee with a corrective action plan as warranted.

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The facility failed to provide clinical rationale for the use of duplicative hypnotic drug therapy for the treatment of R38's insomnia, including showing the benefits vs risks for the long-term use of these medications. Additionally, they failed to provide clear indications for the use of her prn medications and failed to monitor their effectiveness. Findings were confirmed with E1 (Administrator) and E4 (Corporate Nurse) on 12/9/10.

2. R106 was admitted to the facility on 9/28/10 with multiple diagnoses including Parkinson's disease and dementia.

Review of R106's medications revealed that he took Seroquel 12.5 mg, an antipsychotic medication, at bedtime for agitation.

The monthly Drug Regimen Review for R106 revealed a pharmacist's note, dated 11/24/10, that stated, "Seroquel added for agitation... No AIMS." The clinical record lacked evidence of any AIMS (abnormal involuntary movement scale) testing.

During an interview with E4 on 12/8/10, she stated that it was facility policy to conduct AIMS testing when a resident is started on an antipsychotic medication to use as a baseline for monitoring side effects. She acknowledged that the facility should have completed an AIMS test for R106 when he first started on the Seroquel.

3. R95 was admitted to the facility on 10/17/08 and had diagnoses that included dementia, Alzheimer type with depression and delusions.

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F 329 Continued From page 32 F. 329

Review of physician's orders revealed that on 7/27/10 an order was written for R95 to receive Alprazolam (Xanax) 0.25 mg 1 tablet every 8 hours as needed for anxiety.

A care plan for the problem, "Episodes of inappropriate behavior" was initiated on 8/24/10. Approaches included, "Staff will monitor & document episodes of inappropriate behavior. Redirect and use calm approach. Attempt to ascertain and eliminate cause of behaviors. Medicate as ordered and monitor for effectiveness." A second care plan entitled, "Episodes of anxiety..." included the approaches, "Medicate as ordered; Monitor for (side effects)...If possible, ascertain what is causing episodes of anxiety...Monitor and document effectiveness of medication..."

Medication records, nurse's notes and behavior flow records reviewed from 9/13/10 through 12/7/10 failed to indicate on 36 occasions that R95 either had anxiety that warranted the use of the Xanax or that the facility attempted any non-pharmacological interventions prior to use of the Xanax. Additionally, the facility failed to monitor the effectiveness of the medication on multiple occasions.

On 12/9/10 during an interview with E1 (Administrator) and E4 (Corporate Nurse) they acknowledged that there was a lack of evidence that warranted the use of the Xanax on multiple occasions from 9/10 through 12/10.

4. R12 had diagnoses including hypertension, stroke and dementia. Review of R12's medications revealed that she was taking an antihypertensive medication, Lisinopril since

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F 329	Continued From page 33 9/26/09. R12's physician ordered a Complete Blood Count (CBC) and Basic Metabolic Panel-6 (BMP) to be done yearly in August. The CBC and BMP originally ordered on 10/1/08, were on the 8/10 Physician's Orders Sheet (POS) as well as the 12/10 POS for R12. Review of the 8/10 Medication Administration Record (MAR) revealed that there was no lab work drawn during the month. On 12/7/10 in an interview, E14 (LPN) confirmed this. He further stated that he had checked with the laboratory yesterday and that there was no record of any lab work being drawn in 8/10 for R12. Review of the Medication Regimen Review (MRR) by the pharmacist revealed that E15 (Consultant Pharmacist) noted on 10/13/10 that labs due in 8/10 were not on the chart. The facility failed to adequately monitor an antihypertensive medication, Lisinopril for R12 in relation to doing blood work including CBC, renal/kidney function tests and electrolytes. Findings were confirmed with E4 (Corporate Nurse) during an interview on 12/7/10. E4 stated there was no lab work drawn from 8/10 through 12/7/10. Also, E4 stated the facility should have followed up when the E15's MRR/report noted "no labs", but they failed to do so. 5. R80 was admitted to the facility on 9/24/10 with diagnoses of a fall resulting in a right hand fracture, osteoarthritis of the left knee and a seizure disorder. The admission Medication Regimen Review (MRR) done by E15 (Consultant Pharmacist) on 9/24/10 noted that there were	F 329			

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F 329

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duplicate orders for therapeutically similar medications used to treat osteoporosis, Fosamax and Fortical/Calcitonin. During the 10/13/10 MRR, E15 again noted the duplication and made the same recommendation to the physician. During the 11/24/10 MRR, E15 noted that there was no change to the above recommendations.

On 12/8/10 at 3:39 PM, a telephone interview was conducted with E15. E15 was asked about the use of duplicative orders for Fosamax and Fortical/Calcitonin. E15 stated that there were "possible side effects". E15 further stated that there was nothing brought to light as to why both were needed and expressed concerns regarding the risk of upper gastrointestinal side effects. E15 stated that if one medication was sufficient why risk adding another medication? E15 stated that she did not know of any instances in which both Fosamax and Fortical/Calcitonin were needed. E15 stated that she would call the physician to determine if there was an indication for the use of both medications.

On 12/8/10, E35 (R80's physician) was called by the facility and gave a verbal order, "Continue Fosamax and Fortical despite pharmacy rec (recommendations)/review". However, there was no indication for the use of both medications on the 12/8/10 physician order. In a telephone interview, on 12/9/10 @ 5 PM, E15 reported that E35 had not responded to her call regarding the indication for use of the duplicative medications.

On 12/8/10 at 11:25 AM in an interview with E4 (Corporate RN), the record was reviewed and she confirmed the duplication of Fosamax and Fortical without an indication to use both medications. Additionally, E4 confirmed that E15

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F 329 Continued From page 35
had notified E35 on two separate occasions during the MRRs completion on 9/24/10 and 10/13/10.

F 333 483.25(m)(2) RESIDENTS FREE OF SS=D SIGNIFICANT MED ERRORS

The facility must ensure that residents are free of any significant medication errors.

This REQUIREMENT is not met as evidenced by:

Based on record review and interview, it was determined that the facility failed to ensure that one (R95) out of 31 sampled residents was free of any significant medication errors which occurred over an extended period of time. Findings include:

R95 was admitted to the facility on 10/17/08 and had diagnoses that included dementia, benign prostatic hypertrophy (BPH) with urinary retention and a history of urinary tract infections (UTI). A "Report of Consultation," dated 7/31/09 and completed by a urologist, recommended "Flomax 0.4 mg 1 (by mouth) daily 1/2 hour after supper."

Review of the physician's order sheet (POS) and medication administration record (MAR), both dated 7/31/09, revealed that the order was transcribed correctly. Review of the 8/09 MAR revealed the Flomax was given correctly 1/2 hour after dinner.

The pharmacy pre-printed 9/09 MAR and monthly POS incorrectly which stated the Flomax was to be administered "30 minutes before dinner" and noted the hour of administration as "0900" (9 AM). During the monthly recapitulation of

F 329

F 333

F 333

2/4/11

1. R 95 remains in the facility. - Physician was notified and clarifying order was received. POS and MAR were verified to accurately reflect clarifying order. No negative outcome was identified.
2. All residents have the potential to be affected by this cited practice.
3. All licensed staff will be provided re-education and be assessed for competency on recapitulation orders and the 24 hour chart check process with emphasis placed on the accuracy of orders. All residents readmitted to the facility will have transfer medications orders reconciled to prior medication orders within 24 hours of readmit by the Unit Manager/Nurse Designee. Any discrepancy in orders with regard to medication administration times, and dosage will be clarified with the physician. Nursing will also fax to Pharmacy the original transfer orders for review to ensure accurate reconciliation and transcription of orders has been completed. All errors identified will be corrected. License staff will also be provided in-service education on reconciling of medication

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F 333 Continued From page 36
physician's orders, facility staff corrected the time of administration to read "1830" (1/2 hour after dinner) on the MAR, but failed to correct the "30 minutes before dinner" to 1/2 hour after dinner.

The pharmacy pre-printed 10/09 MAR and monthly POS incorrectly stated the Flomax was to be given 30 minutes before dinner and noted the time of administration as "2000" (8 PM). During the monthly recapitulation of medications the facility failed to identify the error.

Review of MARs revealed that R95 continued to receive Flomax at 8 PM, instead of 1/2 hour after dinner, during the months of 11/09, 3/10, 4/10, 8/10, and 9/10. The 12/09, 1/10, 2/10, 5/10, 6/10 and 7/10 MARs were missing from the clinical record.

During the 10/10 monthly recapitulation of physician's orders, facility staff changed the administration time of the Flomax to be given at 4:30 PM to coincide with "30 minutes before dinner" that was pre-printed by the pharmacy. As a result, R95 received the Flomax incorrectly from 10/1/10 through 12/6/10.

On 12/8/10 at 2:30 PM the current blister pack of Flomax was observed in the medication cart. The label erroneously stated "1/2 hour before dinner."

The facility failed to correctly complete monthly recapitulation of physician's orders which resulted in R95 receiving Flomax at the incorrect time for approximately 9 months. Findings were acknowledged by E1 (Administrator) and E4 (Corporate Nurse) during a meeting on 12/9/10.

F 364 483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, SS=E PALATABLE/PREFER TEMP

F 333 4. A monthly random audit of 10 % of the resident population will be completed to ensure that each resident's MAR and Physician order sheets and have been recapitulated and reconciled accurately. Findings will be corrected as warranted and reviewed in the quarterly QI meeting.

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F 364	Continued From page 37 Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on resident interviews and test trays, the facility failed to provide food that was palatable and at the proper temperature. Findings include: During Stage 1 resident interviews, three residents (who preferred not to be identified) stated that food was not served warm enough. Two test trays were pulled on 12/6/10 at approximately 12:15 PM. 1. One test tray included tomato soup which was 120 degrees F, a cheeseburger which was 113 degrees F, and cooked carrots which were 111 degrees F. When tasted, all three items were determined to be not warm enough to be palatable. Additionally, the milk on the tray was 54 degrees F and the ice cream was partially melted. Both items were tasted and determined to be unpalatable. 2. The second test tray had tomato soup that was 123 degrees F, which was lukewarm. The tuna melt was 128.8 degrees F and was also lukewarm. Additionally, the english muffin which was the bread that the tuna melt was placed on was difficult to cut with a knife and difficult to chew. The cooked carrots were 114.6 degrees F. The tomato soup, tuna melt and carrot coins were	F 364	F 364 1. No resident was identified by the deficient practice. 2. All residents have the potential to be affected by this cited practice. 3. The Food and Beverage Director / Designee will routinely monitor food temperatures at point of service to the resident to assure proper food temperatures are maintained. Any identified temperature issues will be resolved at time of finding. The appropriate dining and kitchen staff will be in-serviced on facility policy for safe food temperatures to assure compliance. 4. The Food and Beverage Director / Designee will conduct random weekly audits utilizing the dining services meal review form and food temperature log form. Findings will be reported monthly x 2 then quarterly to QA committee with a corrective action plan as warranted.	2/4/11

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F 364	Continued From page 38 found to be not palatable.	F 364		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH	F 425	F 425 Cross refer to F 333	2/4/11
	<p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p>		<p>1. R4 – Resident was discharged from the facility. R 95 remains in the facility. - Physician was notified and clarifying order was received. POS and MAR were verified to accurately reflect clarifying order. No negative outcome was identified.</p>	
	<p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p>		<p>2. All residents have the potential to be affected by this cited practice. A complete MAR to cart audit was completed to assure discontinued medication had been removed from the carts. No new issues were identified.</p>	
	<p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.</p>			
	<p>This REQUIREMENT is not met as evidenced by: Based on observations and record reviews, it was determined that the facility failed to ensure pharmaceutical services that included accurate dispensing of all drugs to meet the needs of two (R4 and R95) out of 31 sampled residents. The facility failed to ensure the removal of R4's Ativan (for anxiety) tablets from the medication cart on 11/11/10 when the Ativan was discontinued, they failed to identify that Ativan was left on the cart during chart checks on 11/11/10, and the facility failed to do the 12/10 recapitulation of physician</p>			

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F 425 Continued From page 39
orders and the order for Ativan prn (as needed) incorrectly remained on the MAR (Medication Administration Record). On 12/7/10, #26 Ativan tablets were found on the medication cart with the potential to be given to R4. Findings include:

Cross refer, F333
1. R95's "Report of Consultation," dated 7/31/09 and completed by a urologist, recommended the following: "Flomax 0.4 mg 1 (by mouth) daily 1/2 hour after supper."

Review of the physician's order sheet (POS) and medication administration record (MAR), both dated 7/31/09, revealed that the order was transcribed correctly by facility staff.

The pharmacy pre-printed 9/09 MAR and monthly POS incorrectly stated the Flomax was to be administered "30 minutes before dinner" and noted the hour of administration as "0900" (9:00 AM). R95 received the Flomax not at the time prescribed by the physician for approximately 13 months.

Observation of R95's current blister pack of Flomax on the medication cart revealed that the label erroneously stated, "1/2 hour before dinner."

2. The facility policy entitled "Medication and Treatment Order Guidelines, dated 3/4/04, stated, "... Discontinue an order by writing "D/C" across the section on the MAR..., including initials and date. Also write "D/C" next to the order on the Physician's Order Sheet... The appropriate nurse is notified and the medication removed from the medication cart..."

R4 was readmitted to the facility from the hospital

F 425 3. All licensed staff will be provided re-education and be assessed for competency on recapitulation orders and the 24 hour chart check process with emphasis placed on the accuracy of orders. All residents readmitted to the facility will have transfer medications orders reconciled to prior medication orders within 24 hours of readmit by the Unit Manager/Nurse Designee. Any discrepancy in orders with regard to medication administration times, and dosage will be clarified with the physician. Nursing will also fax to Pharmacy the original transfer orders for review to ensure accurate reconciliation and transcription of orders has been completed. All errors identified will be corrected. License staff will also be provided in-service education on reconciling of medication. All discontinued medications will be documented on the 24 hour report and the cart will be checked against the MAR by the charge nurse assigned to assure timely removal of discontinued medications from medication cart.

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F 425	<p>Continued From page 40</p> <p>on 10/28/10. Hospital orders, dated 10/28/10, listed Ativan 1 mg to be given every 6 hours prn (as needed) and Xanax 0.25 mg tablet, take 1/2 tab (0.125 mg) by mouth 3 times a day prn for anxiety. The facility physician ordered these medications as written. On 11/11/10, another physician order was written to discontinue the Ativan.</p> <p>Ativan was written to be d/c'd (discontinued) on the 11/10 MAR, yet on 12/7/10, the order for Ativan remained active on the 12/10 MAR. Findings were confirmed by E4 (corporate nurse) during an interview on 12/7/10. E4 confirmed that #26 Ativan 1 mg tablets remained in the medication cart on 12/7/10 which posed a potential for medication errors. E4 stated that no one signed the 12/10 recapitulation as having been completed (review of physician orders), so the order for Ativan incorrectly remained on the 12/10 MAR and was not identified. E4 subsequently d/c'd the Ativan order from the 12/10 MAR, removed it from the cart.</p> <p>Additionally, the facility failed to identify that the Ativan was not removed from the medication cart when it was d/c'd on 11/11/10 during chart checks signed as completed on the 3-11 and 11-7 shifts.</p> <p>The facility failed to provide pharmaceutical services for R4 related to Ativan according to current standards of practice, including identification of the prevention of potential medication errors and the proper disposition of discontinued medication.</p>	F 425	<p>4. A monthly random audit of 10 % of the resident population will be completed by the DON/Nurse Designee x3 months then quarterly to ensure that each resident's MAR and Physician order sheets and have been recapitulated and reconciled accurately. Also, random cart audits will be completed weekly x1 month and then monthly x 3months to assure discontinued medications are removed timely from cart to prevent errors. Findings will be submitted to the administrator and reviewed in the quarterly QI meeting with corrective action as warranted.</p>
F 441	483.65 INFECTION CONTROL, PREVENT SS=E SPREAD, LINENS	F 441	
The facility must establish and maintain an			

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F 441	<p>Continued From page 41</p> <p>Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, review of facility</p>	F 441 F 441	<p>2/4/11</p> <ol style="list-style-type: none"> R 173 is no longer in the facility. – Upon identification by surveyor, contact precaution procedures were immediately implemented which included appropriate notification signage. Identified issues in room's 104, 108, 111 & 145 were addressed at time of survey. All residents, staff, and visitors have the potential to be affected by this cited practice. At the time of survey, the facility conducted a review of all in-house residents for identification of medical conditions which required specific infection control interventions. Immediate corrective action was taken for identified residents. All Nursing and Environmental staff will receive in-service education on the facility policy for initiating isolation procedures to assure compliance. An infection control line list has been implemented and will be maintained. The DON/Nurse Designee assigned as the infection control coordinator will track and monitor infections daily. Findings will be documented and communicated in the daily IDT meeting to assure compliance with all disciplines. All direct care staff will be provided in-service education on proper handling of soiled linen, contaminated linen, and proper disposal of trash.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085036	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/10/2010
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NAME OF PROVIDER OR SUPPLIER FORWOOD MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 1912 MARSH ROAD WILMINGTON, DE 19810
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F 441 Continued From page 42
documents and staff interviews, it was determined that facility failed to maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease in regards to:

- The facility failed to ensure that the information in the Infection Control surveillance records, or line listing, maintained by the facility was used to determine if any corrective actions were warranted to control and prevent infections in the facility.
- Facility failed to determine that a resident needed isolation to prevent the spread of infection in regards to identification of such residents.
- The facility failed to handle, store and process linens to prevent the spread of infection. Findings include:

The facility's Infection Control Policies and Procedures were reviewed.

1. Review of the Monthly Infection Control Logs/records entitled "Antimicrobial Resistant Organisms List" for January 2010 through November 2010 and the monthly "Facility-Associated Infections" report revealed that the facility monitored the occurrence of infections and analyzed the data for infections; however, it failed to establish controls to prevent the spread of infections in the facility.

Monthly tracking data review or "Facility-Associated Infections" reports from 1/10 to 11/10 revealed that the facility had no record of how the facility responded to the data, however, interview with E4 (Corporate Nurse) revealed that this information was found in the QA reports

F 441
4. The Environmental Services Director/Designee will conduct weekly audits to confirm compliance with established policies & procedures. Any identified issues will be resolved at time of findings. Findings will be submitted to the administrator monthly x 3 mos. and reviewed in the QI meeting with corrective action as warranted.

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F 441	Continued From page 43 which the surveyors did not review.	F 441		
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Interview with E2 (DON) and E4 on 12/8/10 at approximately 10:15 AM revealed that the facility also maintained a line listing, in addition to those done by E23 (Infection Control Contract Nurse); however E2 and E4 were unable to locate the infection data.

The facility failed to act upon the findings of infection data and analysis to control infections at the facility. The facility failed to take corrective actions and failed to establish controls to prevent infections in the facility

2. Review of the facility procedure, entitled, "Initiating Isolation Procedures" stated that signs had to be posted on the room doors of residents with infections, instructing staff and visitors to report to the nursing station before entering the room.

Medical record review revealed that R173 had C-diff (Clostridium Difficile, intestinal infection causing diarrhea).

R173 was interviewed in room 126A on 11/29/10 and the room door had no contact precaution sign posted to alert other residents, staff, and visitors that this resident had an infectious disease that could be contagious and special precautions/measures needed to be taken to prevent others from acquiring the disease.

Observations made during the environmental tour on 12/6/10 with E24 (Maintenance Director) and E26 (Housekeeping Supervisor) revealed that R173's had changed rooms (108) and the door

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F 441 Continued From page 44 F 441

again had no isolation precaution sign. Interview with E24 and E26 on 12/6/10 revealed they were unaware that the room required isolation precautions.

Interview with E23 (Infection Control Contract Nurse) on 12/7/10 at 8:36 AM revealed that the signs were required for residents with C-diff. She confirmed that R173 (and three other residents) presently had infections and no isolation precaution signs were posted on their room doors.

Interview with E2 on 12/8/10 revealed that R173 was moved to a room by himself due to roommate conflicts and to having C-diff. E2 confirmed signs should have been posted on the doors.

The facility failed to identify that a resident needed isolation to prevent the spread of infection.

3. Observations of resident rooms 104 and 108 bathrooms during the environmental tour on 12/6/10 at approximately 11:15 AM with E24 (Maintenance Director) and E26 (Housekeeping Supervisor) revealed unbagged soiled linen, and or soiled personal laundry stored on top of the laundry hampers. The resident in room 108 had C-diff. (R173). Additionally, bags of soiled linen and/or soiled diapers were observed on the floor of resident rooms 111 and 145 on 12/9/10 at approximately 8:20AM.

Interviews with staff (E24 and E26) on 12/6/10 confirmed these findings. They confirmed that the soiled linen should have been picked up right away.

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F 441 Continued From page 45

F 441

Observations of the laundry room on 12/6/10 revealed that the bags of soiled linen from all residents' rooms were removed from the bags and mixed in a cart in the washer area, then washed together. E26 stated that soiled linen from residents' rooms on contact precaution (or on isolation) required a special bag and these bags should be placed in the washer untouched by the staff and not mixed with the regular soiled linen on the cart.

Interview with E35 (Nursing staff), on 12/6/10, acknowledged that the soiled linen should have been placed in bags and not left on top of hamper.

On 12/9/10, E1 and E4 acknowledged these findings.

The facility failed to handle soiled linen in a way to prevent infection. Soiled linen from resident rooms on contact precautions were not handled appropriately.

F 501 cross refer to F329

2/4/11

F 501 483.75(i) RESPONSIBILITIES OF MEDICAL DIRECTOR
SS=D

F 501

The facility must designate a physician to serve as medical director.

The medical director is responsible for implementation of resident care policies; and the coordination of medical care in the facility.

This REQUIREMENT is not met as evidenced by:
Based on interviews and record reviews, it was determined that the Medical Director failed to

1. **R 38** – A medication review was completed with the Medical Director of resident's order for Sonata, Xanax and Ambien. The Medical Director had a verbal conversation with the resident's attending physician to importance of gradual drug reduction and for providing clinical rationale for duplicative drug therapy on 1/20/11. The facility psychiatrist has been consulted to review resident's current drug regimen for sleep.

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F 501 Continued From page 46
coordinate care for one (R38) out of 31 sampled residents. The Medical Director failed to ensure that there was a process in place for her notification when R38 was receiving duplicative drug therapy. Findings include:

Cross refer to F329, example #1
R38 was receiving duplicative hypnotic drug therapy for insomnia since 4/15/09. Additionally, she was receiving antianxiety medication on a regular basis since 4/15/10.

Review of R38's clinical record lacked evidence of a thorough medication review or an attempted drug reduction trial.

Interviews with E8 (MDS Coordinator) and E18 (Director of Social Services) on 12/7/10, confirmed that R38's physician, E35, refused to attend medication reduction meetings in the facility unless he had at least 10 residents residing there. On 12/15/10, during a telephone interview, E8 stated that all the resident's medications were reviewed at the medication reduction meetings.

During an interview with E19 (Medical Director), on 12/8/10, she stated that she had not been informed of E35's refusal to attend medication reduction meetings until that day. She stated that she planned to write E35 a letter to inform him that attendance at these meetings was a facility requirement.

- F 501 2. All residents on duplicative antipsychotic medications have the potential to be affected by this cited practice. A medication audit will be completed on all residents currently on psychopharmacological medications to identify duplicative therapy and to assure a physician review has been done to assure unnecessary drug use.
3. The behavior review committee will be re-educated on the goals and objectives guidelines as outlined for monitoring behaviors and to assure appropriate measures are taken for gradual medication reductions and review of psychopharmacological medications on all residents taking duplicative antipsychotic medications.
4. DON/designee to review and follow up as necessary from monthly pharmacy review and behavior review committee to assure compliance. Findings to be reported monthly x 3 mos. to QA committee with a corrective action plan as warranted.

F 502 483.75(j)(1) PROVIDE/OBTAIN LABORATORY SS=D SVC-QUALITY/TIMELY

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

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F 502	<p>Continued From page 47 of the services.</p> <p>This REQUIREMENT is not met as evidenced by: Based upon record review, the facility failed to provide lab services that were ordered for one resident (R12) out of 31 sampled residents. Findings include:</p> <p>R12 had a CBC (Complete Blood Count) and BMP (Basic Metabolic Panel) ordered yearly in August. Review of the record including the laboratory section and the Medication Administration Record (MAR) for 8/10 revealed that there was no lab noted to be drawn and there were no lab results for that month.</p> <p>Review of the monthly Medication Regimen Review (MRR) revealed that on 10/13/10, E15 (Consultant Pharmacist) noted that the August labs were not on the chart.</p> <p>On 12/7/10 in an interview, E14 (LPN) stated that no lab work was drawn during August 2010 for R12. Additionally, E14 stated that he called the lab yesterday and the lab stated that there was no record of any lab work being drawn from 8/10 through 12/7/10 for R12.</p> <p>On 12/7/10, in an interview E4 (Corporate Nurse) confirmed that the facility failed to have lab work drawn as ordered by R12's physician. E4 stated that the facility should have followed up when E15's review/report noted no labs but failed to do so.</p>	F 502 F 502	<ol style="list-style-type: none"> R12 remains in the facility and a CBC and BMP was completed on 12/16/10 and reviewed by the physician with no new orders recommended. All residents have the potential to be affected by this cited practice. All current resident charts will be audited to ensure labs are current and timely as per physician orders. All current license staff will be in-serviced on the lab ordering process and procedure for following up of lab orders. Lab Book will be reviewed daily by the 11-7 Supervisor to ensure labs have been drawn timely. A Monthly audit will completed on resident's charts with ordered labs for each month by the DON/ Nurse Designee and findings will be submitted to the administrator and reviewed in the quarterly QI meeting to ensure compliance with corrective action plan as warranted. 	2/4/11
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE	F 514		

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F 514 Continued From page 48

The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.

The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.

This REQUIREMENT is not met as evidenced by:
Based on interview and record review the facility failed to maintain clinical records that were complete and accurately documented for two (R38 and R95) of 31 sampled residents. Findings include:

Cross refer to F329, example #1
1. R38 was receiving prn (as needed) medications for insomnia and anxiety.

a. Review of R38's clinical record revealed an "Individual Certificate for Disposition for Control Drugs" for the administration of Sonata, 10 mg as needed for insomnia. During the month of 11/10, the medication was signed off as given 21 times. Review of R38's Medication Administration Record (MAR) for 11/10, revealed that the medication was only documented as given 19 times. Additionally, there was no documentation found on the MAR indicating the need for the medication.

F 514 F 514 – Cross refer to F 329

2/4/11

1. R 38 & R95 – No negative outcomes were identified by the deficient practice.
2. All residents have the potential to be affected by this cited practice.
3. All licensed staff will be inserviced on proper documentation guidelines for administration of medications in accordance with facility policies & procedures with emphasis on the documentation of routine and prn narcotics on the medication record.
4. A monthly random audit of 10 % of the resident population will be completed to ensure that documentation is accurate for each resident's MAR and associated Individual Certificate of Controlled Drugs. Findings will be submitted to the administrator and reviewed in the quarterly QI meeting with corrective action as warranted.

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F 514 Continued From page 49

b. Review of R38's clinical record revealed an "Individual Certificate for Disposition for Control Drugs" for the administration of Xanax, 0.25 mg as needed for anxiety. During the month of 11/10, the medication was signed off as given 29 times. Review of R38's MAR for 11/10, revealed that the medication was only documented as given 19 times. Additionally, there was no documentation found on the MAR indicating the need for the medication.

F 514

2. Review of R95's "Individual Certificate of Disposition for Control Drugs" for the administration of Alprazolam (Xanax) 0.25 mg tablets revealed that from 9/17/10 through 12/5/10 the facility failed to document corresponding signatures on the MAR signifying doses that were given on 20 occasions.

The facility failed to ensure that R95's clinical record was complete and accurately documented.

F 518 483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS

F 518

The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures.

This REQUIREMENT is not met as evidenced by:
Based on in-service documentation reviews, facility policies and procedures review, and staff interviews, it was determined that the facility failed to ensure that five (5) of sixteen (16) sampled staff (E27, E28, E29, E30, E31) were trained in emergency procedures when they began work at

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F 518 Continued From page 50
the facility or periodically thereafter. Findings include:

Staff interviews on 12/6/10 and 12/7/10 were conducted to determine if staff had emergency preparedness training and were ready to handle an emergency situation at the facility. E27 (CNA) responded that he had not had training since being hired at the facility.

Review of the facility "New Employee Orientation Policy" revealed that the "Company provides a general orientation program for all new employees during their first ten days of their employment. Generally the employee completes the facility orientation program on the first day of employment; however, if an employee begins employment on a day when orientation is not scheduled, he/she must report directly to his/her assigned department for departmental orientation". The Policy stated under "Section 4.0" entitled "Guidelines" that "on day one: employees may not begin work without participating in this section. The following subjects must be covered on Day One of employment regardless of whether the employee participates in General or Departmental orientation: 1.b. Environment, Safety and Emergency preparedness and k. Elopement "...2. In the General Orientation, the following must be completed in the General Orientation Program (in addition to above)...Safety and Emergency Procedures..... "5. Procedure Step 1 stated that "During the first week of employment, each new employee will attend the general orientation program", "and complete the appropriate new hire documents".

The Training Kit for the facility was reviewed on

F 518 F 518 2/4/11

1. No residents were identified for the identified deficiency. E28 is no longer employed. Identified staff will receive inservice training on facility Emergency Preparedness Policy/Procedure
2. Human Resources Director/designee will complete an audit to identify other current employees who may not have received Emergency Preparedness Training. Any identified employees will receive required inservice education.
3. New Hire Orientation process will be evaluated and restructured as necessary to ensure new employees receive appropriate training in accordance with facility's Policy & Procedure.
4. A monthly audit will be completed by the Human Resources Director/designee Findings to be reported monthly x 3 mos. to QA committee with a corrective action plan as warranted.

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F 518	<p>Continued From page 51</p> <p>12/8/10 with E33 (Human Resources Manager) and it stated that "All new employees, temporary workers and volunteers need to receive training in these topics before they work with residents ...Objectives: at the end of this section, the participant (s) will be able to recognize:5. Policies and practices to ensure resident safety andelopement,7. Plans and procedures for responding to fires, weather and utility disasters,". The Checklist listed all types of emergencies such as bomb threat, earthquakes, tornadoes, fire, evacuation, elopement, etc.</p> <p>Facility in-service records were reviewed for sixteen staff on 12/8/10 and 12/9/10. Documentation of in-service training to validate which staff had emergency training out of the sixteen was not available for five staff as shown below.</p> <ol style="list-style-type: none"> 1. E27 (CNA) hired on 9/21/10 had no emergency preparedness training since hire. 2. E28 (LPN) hired on 11/15/10 had no emergency preparedness training since hire. 3. E29 (PT) hired on 6/28/10 had no emergency preparedness training since hire. 4. E30 (PT) hired on 1/4/10 had no emergency preparedness training since hire. 5. E31 (PT) hired on 3/31/08 had no emergency preparedness training since hire. <p>On 12/9/10, in an interview E32 (Staff Development Nurse) and E33 confirmed these findings. Further interviews with E1 (Administrator) and E4 (Corporate Nurse) acknowledged this finding.</p>	F 518		
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**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

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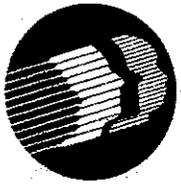
NAME OF FACILITY: Forwood Manor

DATE SURVEY COMPLETED: December 10, 2010

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
<p>3201</p> <p>3201.1.0</p> <p>3201.1.2</p>	<p>Revised report with staffing review.</p> <p>An unannounced annual survey and complaint visit was conducted at this facility from November 29, 2010 through December 10, 2010. The deficiencies contained in this report are based on observation, interviews and review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was sixty-three (63). The survey sample totaled thirty-one (31) residents.</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> <p>This requirement is not met as</p>	

Daniel Bell, EXECUTIVE DIRECTOR

2/7/11



**DELAWARE HEALTH
AND SOCIAL SERVICES**

Division of Long Term Care
Residents Protection

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3 Mill Road, Suite 308
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STATE SURVEY REPORT

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NAME OF FACILITY: Forwood Manor

DATE SURVEY COMPLETED: December 10, 2010

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
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<p>16 Del. C., Chapter 11, Subchapter V11, §1162</p>	<p>evidenced by:</p> <p>Cross refer to CMS 2567-L survey date completed 12/10/10, F223, F225, F241, F246, F253 F272, F274, F278, F309, F315, F318, F329, F333, F364, F425, F441, F501, F502, F514, and F518.</p> <p>The DLTCRP conducted an annual and complaint survey at Forwood Manor, entering on 29 November 2010 and exiting on 10 December 2010. This report concerns the results of the facility staffing review performed in conjunction with this visit.</p> <p>Nursing Staffing:</p> <p>(c) By January 1, 2002, the minimum staffing level for nursing services direct caregivers shall not be less than the staffing level required to provide 3.28 hours of direct care per resident per day, subject to Commission recommendation and provided that funds have been appropriated for 3.28 hours of direct care per resident for Medicaid eligible reimbursement.</p> <p>Nursing staff must be distributed in order to meet the following minimum weekly shift ratios:</p> <table data-bbox="276 1753 755 1900"> <thead> <tr> <th></th> <th>RN/LPN</th> <th>CNA*</th> </tr> </thead> <tbody> <tr> <td>Day</td> <td>1:15</td> <td>1:8</td> </tr> <tr> <td>Evening</td> <td>1:23</td> <td>1:10</td> </tr> <tr> <td>Night</td> <td>1:40</td> <td>1:20</td> </tr> </tbody> </table> <p>* or RN, LPN, or NAIT serving as a</p>		RN/LPN	CNA*	Day	1:15	1:8	Evening	1:23	1:10	Night	1:40	1:20	<p>16 Del. C., Chapter 11, Subchapter V11, ss 1162.</p> <ol style="list-style-type: none"> 1. No residents were identified for the identified deficiency. 5. All residents have the potential to be affected by this cited deficiency. 2. A system for monitoring staffing schedules has been implemented to ensure minimum staffing requirements are met on a daily basis. 3. A monthly audit will be completed by the DON/designee. Findings to be reported monthly x 3 mos. to QA committee with a corrective action plan as warranted. <p>Completion Date: 2/4/11</p>
	RN/LPN	CNA*												
Day	1:15	1:8												
Evening	1:23	1:10												
Night	1:40	1:20												



**DELAWARE HEALTH
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Division of Long Term Care
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	<p>CNA.</p> <p>(g) The time period for review and determining compliance with the staffing ratios required under this chapter shall be 1 week.</p> <p>Three weeks of facility staffing, covering the period of 25 October 2010 through 14 November 2010 inclusive, were reviewed to verify compliance with Delaware Nursing Home Staffing Laws, commonly known as Eagles' Law. Several other dates were also similarly reviewed, pursuant to a complaint received by the DLTCRP. These reviews consisted of data entered on the DLTCRP Staffing Worksheets by Forwood staff, and signed by the Administrator. Several dates were further checked through daily schedules and payroll hours reports. The four (4) citations hereon result from that work.</p> <p>The law was not met as evidenced by:</p> <p>Forwood Manor failed to meet the 3.28 Daily Care Hours per Resident requirement on the following four (4) dates. The care hours attained on those dates are parenthesized.</p> <ol style="list-style-type: none"> 1. Saturday, 4 September 2010 (3.24) 2. Friday, 5 November 2010 (3.07) 3. Sunday, 7 November 2010 (3.20) 4. Monday, 8 November 2010 (3.18). 	
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	<p>An unannounced annual survey and complaint visit was conducted at this facility from November 29, 2010 through December 10, 2010. The deficiencies contained in this report are based on observation, interviews and review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was sixty-three (63). The survey sample totaled thirty-one (31) residents.</p>	
3201	<p>Regulations for Skilled and Intermediate Care Facilities</p>	
3201.1.0	<p>Scope</p>	
3201.1.2	<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>	
	<p>This requirement is not met as evidenced by:</p>	

David R. [Signature], EXECUTIVE DIRECTOR 1/31/11



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	<p>Cross refer to CMS 2567-L survey date completed 12/10/10, F223, F225, F241, F246, F253 F272, F274, F278, F309, F315, F318, F329, F333, F364, F425, F441, F501, F502, F514, and F518.</p>	<p>Cross refer to CMS 2567-L. POC for survey date completed 12/10/10, F223, F225, F241, F246, F253, F272, F274, F278, F309, F315, F318, F329, F333, F364, F425, F441, F501, F502, F514, and F518.</p> <p>Completion Date: 2/4/11</p>