

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

PRINTED: 10/31/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  08E029	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  10/20/2011
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NAME OF PROVIDER OR SUPPLIER  GOVERNOR BACON HEALTH CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE P.O. BOX 559 DELAWARE CITY, DE 19706
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**INITIAL COMMENTS**  
  
An unannounced annual survey and was conducted at this facility from October 11, 2011 through October 20, 2011. The deficiencies contained in this report are based on observation, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was eighty-one (81). The survey sample totaled twenty-nine (29) residents.

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**483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)**  
  
A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).  
  
The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Director	(X6) DATE 11/14/11
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deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that 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 157	<p>Continued From page 1 this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for one (R63) out of 29 residents sampled the facility failed to consult with the physician and failed to notify the resident's legal representative when there was a change in a resident's condition. R63 had a new pressure ulcer of the left hip and the facility failed to consult with R63's physician and failed to notify the legal representative. Findings include:</p> <p>R63 was originally admitted to the facility on 7/28/11 from the hospital with diagnoses of urinary tract infection and urethral stricture. In addition, R63 had diagnoses including Parkinson's Disease, diabetes mellitus, failure to thrive, hypertension, benign prostatic hypertrophy, severe advanced dementia, coronary artery disease, hypertension, and gastroesophageal reflux disease, and history of sacral PU. R63's admission Minimum Data Set (MDS) assessment dated 8/8/11 revealed that the resident was severely impaired for daily decision making, required total assistance of two persons for bed mobility/transfer and was incontinent. In addition, R63 was at risk for developing PU and did not have any PU at the time of this assessment.</p> <p>Review of R63's nurse's note (N.N.) dated</p>	F157	<p><b>Immediate</b> – Resident R63 who was admitted as a terminal resident lived 19 days at Governor Bacon Health Center; unfortunately the last week of his life, he developed a Stage I pressure ulcer to his left hip.</p> <p><b>Identify</b> – At the time of the survey, there were two residents with pressure ulcers. The RN supervisor reviewed both residents' charts and assessed that notification of a change in a resident's condition had been completed.</p> <p><b>Systemic</b> – GBHC Nursing Department will monitor and review notification of the physician, dietitian and legal representative of any resident who develops a pressure ulcer at the weekly Interdisciplinary Care Plan (ICP) meeting.</p> <p>Pressure ulcer procedures/guidelines will be developed and implemented.</p> <p>GBHC will provide in-service training for staff on the pressure ulcer procedures/guidelines including notification of the physician, dietitian and legal representative of any resident with changes such as a pressure ulcer. This in-service will be attended by all nurses. GBHC will purchase a presentation from the National Pressure Ulcer Board.</p> <p><b>Monitoring</b> – GBHC will develop a quality indicator to track compliance with this issue and review findings at the Quality Assurance Committee meetings quarterly.</p>	<p>Resident died on 8/24/11</p> <p>10/21/11</p> <p>10/21/11 and ongoing</p> <p>11/18/11</p> <p>11/21/11 to 12/16/11</p> <p>11/22/11 and ongoing</p>

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F 157	<p>Continued From page 2</p> <p>8/20/11 timed 3:45 AM documented "dark purple discolored area observed to left hip-4.5 cm. (L) x 2.2 cm. (W)-skin intact. Perimeter of discolored area present with some non blanchable erythema. Area offloaded."</p> <p>A new "Pressure Ulcer Record" was initiated on 8/20/11 for the left hip PU as follows: 8/20/11 stage I of the left hip measuring 4.5 cm. (L) x 2.2 cm. (W) with no depth, drainage or odor.</p> <p>Record review lacked evidence that the attending physician, dietician, or R63's legal representative was notified of this new PU of the left hip.</p> <p>An interview with the Director of Nursing/DON (E2) on 10/19/11 at approximately 1 PM revealed that the facility did not have a policy and procedure for pressure ulcer management including staging, however, the facility utilized the Lippincott Manual of Nursing Practice, 9th edition, section titled pressure ulcer, pages 186-188. During a subsequent interview with E2 on 10/21/11, the surveyor requested the policy and procedure for notification of change in condition, however, no information was obtained by the surveyor.</p>	F 157		
F 225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would</p>	F 225		

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F 225	<p>Continued From page 3</p> <p>indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R32) out of 29 sampled residents, the facility failed to immediately report an allegation for misappropriation of resident property and failed to send a five day follow-up on the investigation to the state agency. Findings include:</p>	F225	<p><b>Immediate</b> – GBHC acknowledges the resident’s property was missing and was actively engaged in the investigative process. A PM 46 was submitted to LTCRP during the total investigative process.</p> <p><b>Identify</b> – The Quality Assurance Administrator reviewed all current incident reporting and there were no other allegations of missing property identified.</p> <p><b>Systemic</b> – GBHC will continue to in-service all RN supervisory staff on the electronic submission of incident reports to LTCRP pertaining to alleged violations of neglect, abuse, or misappropriation of property within eight (8) hours.</p> <p><b>Monitoring</b> – Quality Assurance Administrator and Nursing Department will submit, review and discuss all incident reports regarding neglect, abuse, or misappropriation of property for follow-up within five (5) days. These will be discussed at the Quality Assurance Committee meeting quarterly.</p>	10/3/11 10/25/11 10/3/11 and ongoing 11/18/11 and ongoing 11/18/11 and ongoing

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F 225	Continued From page 4 Review of facility documentation revealed that on Friday 9/30/11, R32's wedding ring and engagement ring were discovered missing by direct care staff. The head nurse was notified and the social worker was contacted. Staff statements documented that the social worker, E15, visited the unit to inquire about the rings but had to leave before talking to nursing staff. The facility failed to immediately report the missing rings to the state agency.  On Monday 10/3/11, the incident report on the missing rings was completed and sent to the state agency. The investigation continued by the facility with no success in finding the rings.  An interview with E14, QA administrator, on 10/20/11, confirmed the investigation was ongoing but the facility had not filed a 5 day follow-up report with the state agency.	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, it was determined that the facility failed to provide feeding assistance in a manner that enhanced dignity for two residents observed during dining observation. Findings include:  On 10/11/11, during lunch observation, between	F241	<b>Immediate</b> - The staff was immediately instructed to sit down when feeding a resident to foster a home-like environment. This shows respect and preserves the resident's dignity.  <b>Identify</b> - Through the charge nurse resident assessment process, fifteen other residents were identified needing total assistance with eating. GBHC RN supervisors reviewed resident dignity and respect related to meal service; staff is to sit down when feeding residents.  <b>Systemic</b> - GBHC Nursing Department will monitor and review daily meal service to ensure the residents are treated with dignity and respect.  GBHC will provide a comprehensive in-service to refresh staff on specific ways to promote care for residents that enhances the residents' dignity and respect. The in-service will be attended by all Nursing staff.  GBHC will order additional chairs for the CNAs to sit on when feeding residents.  <b>Monitoring</b> - GBHC Nursing Department will develop a quality indicator to track compliance with this issue; it will be submitted for review at the Quality Assurance Committee meetings quarterly.	10/21/11  10/21/11 and ongoing  10/21/11 and ongoing  11/16/11 to 12/16/11  11/30/11  11/22/11 and ongoing

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F 241	Continued From page 5 12:27 PM and 12:40 PM, E11 was observed feeding R18 while standing up over the resident. Part way through the meal, E11 did get a chair and sat down. E12 was observed feeding R3 while standing throughout the whole meal.	F 241		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES  The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.  This REQUIREMENT is not met as evidenced by: Based on observations made in the resident rooms, it was determined that the facility failed to maintain a sanitary, orderly and comfortable interior. Findings include:  1. On 10/12/11 at 9:52 AM, the D-bed of room 108 had a headboard that had adhesive tape remnants across the surface, covering the edge. This headboard was missing some of the surface veneer. The wall electrical outlet, located behind the headboard, was smashed into the wall. The wall had gouges and scrapes behind the headboard. The B-bed had adhesive tape on the surface and edging, with the edge molding laminate loose and separating from the headboard. The heating and a/c unit had the paint scratched and chipped off, as did the entryway door jamb. Three corners of floor/wall molding were broken and/or separating. The floor/wall molding was missing behind C-bed.  2. At 10:08 AM on 10/12/11, the bathroom of room 109 had a strong urine odor and 2 foot hole	F253	<b>Immediate</b> – The GBHC Maintenance Department did the following: 1. The headboards were replaced. 2. Purchase requisitions were completed to order materials and bring in contractors as necessary to replace floors and fix walls. 1 through 5. Purchase requisition was completed for contracted painters. 2 through 5. Mirrors were replaced.  <b>Identify</b> – A sweep of the facility was done to identify other similar maintenance issues.  A total of 17 mirrors were identified as less than desirable and were replaced.  <b>Systemic</b> – A monthly environmental audit will be conducted by the Facilities Management Department to identify housekeeping and maintenance issues. Housekeeping will continue to clean the bathroom floors with appropriate cleaners for the urine odor until the floors can be replaced.  <b>Monitoring</b> – The environmental audits will be submitted to the Quality Assurance Administrator monthly and reviewed at the Quality Assurance Committee meetings quarterly.	10/21/11 10/21/11  10/21/11 11/3/11  10/12/11 to 10/13/11 11/3/11  12/1/11 and ongoing  12/1/11 and ongoing

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F 253	Continued From page 6 along the wall at the floor next to the toilet. The top half of the mirror in this room was worn on the reflective surface making it unusable from about waist height and up.  3. At 11:40 AM on 10/12/11, the door jamb and the wall next to the bathroom of room 107 had paint scratched or chipped off. The mirror in this room was worn with the reflective surface partially blocked across the middle of the view.  4. On 10/12/11, the mirror in room 111 was worn with the reflective surface partially blocked in the middle of the view. The wall molding adjacent to the sink area had paint scratches and chips.  5. At 12:05 PM on 10/12/11, the mirror of room 108 was worn in the middle of the reflective surface. There was no paint on the wall around the toilet mount and 1/2 of the right wall was not painted.	F 253			
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS  A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.  The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.  The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and	F 279			

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F 279	<p>Continued From page 7</p> <p>psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on clinical record review and interview, it was determined that the facility failed to develop a comprehensive care plan based on identified needs for three (R87, R11 and R63) out of 29 sampled residents. Findings include:</p> <p>1. Review of R87 's initial MDS, dated 8/11/11, documented that the resident expected to be discharged to the community.</p> <p>Review of Social Service notes, dated 9/9/11 and 9/13/11, revealed discussions with R87 on discharge options. Interviews with R87, on 10/12/11 and 10/19/11, revealed that she and family members have met with staff to discuss community resources. This was also confirmed by E15, social worker, on 10/19/11.</p> <p>Review of R87 's care plan, initiated 8/1/11 including updates to 10/14/11, revealed she was not care planned for community discharge. Interview with E13, RN, on 10/14/11, confirmed that there was no care plan developed for discharge planning.</p> <p>2. R11 was admitted 7/25/11. Her initial MDS documented " expects to remain in facility " .</p>	F279	<p><b>Immediate</b> - All resident care plans were immediately reviewed and a unit of care was added for "potential for discharge".</p> <p>Resident R63 who was admitted as a terminal resident lived 19 days at Governor Bacon Health Center, unfortunately the last week of his life he developed a Stage I pressure ulcer to his left hip.</p> <p><b>Identify</b> – 1and 2. All residents care plans were reviewed for potential discharge. 3. At the time of the survey, there were two residents with pressure ulcers. The RN supervisor reviewed their pressure ulcer care plans and they were complete.</p> <p><b>Systemic</b> – 1and 2. GBHC will continue to review all care plans upon admission and quarterly.</p> <p>3. GBHC Nursing Department will monitor and review all pressure ulcer care plans at the weekly Interdisciplinary Care Plan (ICP) meeting.</p> <p>Pressure ulcer guidelines will be developed and implemented.</p> <p>GBHC will provide in-service training for staff on the pressure ulcer guidelines. The in-service will be attended by all Nurses. GBHC will purchase a presentation from the National Pressure Ulcer Board.</p> <p><b>Monitoring</b> – 1 and 2. Social Services will develop a spreadsheet to track all residents, their care plans, their desire for discharge, referrals, and follow-up and will submit to the Quality Assurance Committee quarterly.</p> <p>3. GBHC Nursing Department will develop a quality indicator to track compliance with the pressure ulcer issue, submit documentation to Quality Assurance Administrator and review findings at the Quality Assurance Committee meetings.</p>	<p>11/9/11</p> <p>Resident died on 8/24/11</p> <p>10/21/11 and ongoing</p> <p>11/1/11 and ongoing 10/21/11 and ongoing</p> <p>11/18/11</p> <p>11/21/11 to 12/16/11</p> <p>12/1/11 and ongoing</p> <p>11/22/11 and ongoing</p>

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F 279	Continued From page 8 A social service note dated 9/9/11 documented the resident was interested in pursuing community placement. Subsequent social service notes, dated 9/23/11 and 10/7/11, documented efforts being made to assist R 11 in exploring this option.  Review of R11 's care plan revealed she was not care planned for community discharge planning. Interviews with E13, RN, on 10/14/11, and E15, on 10/19/11, confirmed that there was no care plan developed for discharge.  3. Review of R63's care plan for " impairment of skin integrity: right pressure ulcer stage II implemented on 8/18/11 was revised to include the PU of the two additional PU areas, however, record review lacked evidence of a care plan for the new PU of the left hip identified on 8/20/11.  An interview with E2 (Director of Nursing) on 10/20/11 at approximately 2 PM confirmed that the facility failed to implement a care plan when R63 had acquired a new PU on the left hip on 8/20/11.	F 279			
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING  Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.  This REQUIREMENT is not met as evidenced	F 309			

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F 309	<p>Continued From page 9</p> <p>by: Based on record review and interview, it was determined that for two (R32 and R87) out of 29 residents the facility failed to manage pain according to the facility's plan of care and current standards of practice. Findings include:</p> <p>The following pain management standards were approved by the American Geriatrics Society in April 2002. Facilities must recognize the right of patients to appropriate assessment and management of pain. Facilities must screen patients for pain on admission. If pain is present, they must perform a comprehensive assessment. They must record the assessment in a way that facilitates regular reassessment and follow-up. The same quantitative pain assessment scales should be used for initial and follow up assessment. They must set standards for monitoring and intervention. They must educate providers and assure staff competency. They must establish policies that support appropriate prescription or ordering of pain medicines. They must provide patient and family education on effective pain management. They must include patient needs for symptom control in discharge planning. They must collect data to monitor the effectiveness and appropriateness of pain management.</p> <p>The facility provided a copy of a chapter from a</p>	F309	<p><b>Immediate</b> - Resident R32 and R87 care plans were adjusted to include only one quantitative pain assessment tool. Nursing reviewed with the residents an acceptable level of pain and pain goals.</p> <p><b>Identify</b> – GBHC charge nurses reviewed all residents care plans and adjusted for use of only one quantitative pain assessment tool and for acceptable level of pain and pain goals.</p> <p><b>Systemic</b> - GBHC Nursing Department will monitor and review all care plans for use of only one quantitative pain assessment tool and for acceptable level of pain and pain goals at the weekly Interdisciplinary Care Plan (ICP) meeting.</p> <p>A pain management procedure/guideline will be developed and implemented.</p> <p>GBHC will provide in-service training for staff on the pain management procedure/guideline. The in-service will be attended by all Nurses.</p> <p><b>Monitoring</b> - GBHC Nursing Department will develop a quality indicator to track compliance with this issue. The documentation will be submitted and reviewed at the Quality Assurance Committee meetings quarterly. Additionally, pain management issues will be reviewed at the weekly Interdisciplinary Care Plan meeting.</p>	<p>10/19/11</p> <p>11/7/11 to 11/10/11</p> <p>10/21/11 and ongoing</p> <p>11/18/11</p> <p>11/21/11 to 12/16/11</p> <p>11/22/11 and ongoing</p>

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>08E029</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/20/2011</b>
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F 309	<p>Continued From page 10</p> <p>published nursing care manual titled "special considerations in cancer care pain management" that included the following;</p> <ul style="list-style-type: none"> <li>-Use a pain intensity scale of 0 (no pain) to 10 (worst possible pain) or other pain scale as appropriate.</li> <li>-Assess relief from medications and duration of relief. (use the same measuring scale every time)</li> </ul> <p>1. R32 had diagnoses which included anemia, chronic obstructive pulmonary disease (COPD), constipation, osteoarthritis, dementia, peripheral vascular disease (PVD), diabetes, depression, osteoporosis.</p> <p>The most recent quarterly MDS, dated 9/7/11, documented the resident had pain occasionally that was rated mild on a verbal descriptor scale.</p> <p>The resident's care plan for alteration in comfort pain included the goals and approaches;</p> <p>(1) Resident and/or her caregivers will verbally report pain at an acceptable level. Review date 9/7/11.</p> <p>(2) Resident will have relief from pain and a comfort level that allows continued participation in ADL's and desired activities. Review date 9/7/11 approaches;</p> <ul style="list-style-type: none"> <li>-determine current level of pain in reference to acceptable level of pain by encouraging verbalization of pain. Resident will verbalized her pain on a scale of 1-10 ( mild, moderate, severe). Also note her non verbal behaviors.</li> <li>-assess factors that aggravate or alleviate pain. Determine effect of pain on pursuit of usual</li> </ul>	F 309		
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F 309	<p>Continued From page 11 activities.</p> <p>-monitor therapeutic or non therapeutic effect of analgesics on MAR</p> <p>-administer pain meds as ordered. Resident receives acetaminophen (APAP) 650 mg p q 4 hours prn for pain/temp. Notify physician when acceptable level of pain relief is not maintained.</p> <p>R32 had current physician orders for Percocet 5/325 mg to take one at 6 am and 2 pm for osteoarthritis and APAP 650 mg every 4 hours as needed for pain or temperature.</p> <p>The September 2011 medication administration record (MAR) documented APAP was administered 9/1, 9/9, 9/10, 9/11, 9/23, 9/24, and 9/27/11. No pain scale was used before or after the administration however the medication was noted to be effective.</p> <p>The October 2011 MAR documented APAP administered 10/8, 10/11, 10/12, and 10/13/11. No pain scale was used before or after the administration, however the medication was noted to be effective.</p> <p>Interview with E13, RN, about pain monitoring on 10/19/11 at 2:38 PM, revealed the pain assessment was done by review of the care plan with the MARs and a summary was written. The facility had no specific policy and procedure for pain management. The standards of practice are used in planning care. The use of the mild, moderate, severe scale is used on this resident not the number scale.</p> <p>Record review lacked evidence of a complete pain assessment that included R32's acceptable</p>	F 309		
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F 309	<p>Continued From page 12 level of pain and pain goals.</p> <p>The facility failed to assure that the pain management protocol for R32 met the professional standards of clinical practice as defined by American Geriatrics Society and their own facility guidance. In particular, this facility failed to record a pain assessment in a way that facilitates regular reassessment and follow-up in a timely manner. In addition, as required by the standard of care, the facility failed to use the same quantitative pain assessment tool with each reassessment for pain of R32</p> <p>2. R87 had diagnoses which included; cerebral aneurysm, sarcoidosis, rheumatoid arthritis, hyperlipidemia, depression, seizures, craniotomy, anxiety and Cushing 's syndrome and recently lumbar radiculopathy.</p> <p>The initial MDS, dated 8/11/11, documented that the resident had pain, occasionally that rated on a 4 out of 10 rating scale.</p> <p>The resident ' s care plan for alteration in comfort: pain included the goals and approaches:</p> <p>(1) R87 will have relief from pain. Review date 10/11/11. -assess usual response to pain by verbal report R87 and by monitoring nonverbal behavior -determine current level of pain in NUR reference to acceptable level of pain by encouraging verbalization of pain. R87 will verbalize pain on a scale of mild, moderate, severe or very horrible/severe. Also note nonverbal behaviors</p> <p>(2) R87 will have comfort level that allows</p>	F 309		
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F 309	<p>Continued From page 13</p> <p>continued participation in ADL 's and desired activities. Review date 10/11/11.</p> <p>-monitor therapeutic or non-therapeutic effect of analgesics on MAR</p> <p>R87 had a physician's order for APAP 650mg by mouth every 4 hours as needed for pain/fever was ordered on the medication administration record (MAR). Review of MAR and nursing notes revealed that APAP was dispensed for R87 's complaint of headache/pain on 10/10/11, 10/11/11, 10/12/11, 10/13/11, 10/15/11 and 10/16/11 with the following notation for results: (+) or (+) effect. No pain scale documentation was used as indicated in care plan.</p> <p>The facility failed to record a pain assessment in a way that facilitates regular reassessment and follow-up in a timely manner. In addition, the facility failed to use the pain assessment tool declared in R87's care plan.</p>	F 309		
F 314 SS=D	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, interviews, and review</p>	F 314		

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F 314	<p>Continued From page 14</p> <p>of additional documentation provided by the facility, it was determined that the facility failed to provide the necessary treatment and services to one (R63) out of 29 sampled residents who had pressure ulcers (PUs). The facility failed to have a system/procedure to assure accurate, thorough, and timely assessments when R63 was identified as having PUs. In addition, the facility failed to have a system/procedure to report changes in condition, such as a new PU to the attending physician and the resident's responsible party. Lastly, the facility failed to have a system/procedure to ensure that nutritional consultation was completed timely. Findings include:</p> <p>R63 was originally admitted to the facility on 7/28/11 from the hospital with diagnoses of urinary tract infection and urethral stricture. In addition, R63 had diagnoses including Parkinson's Disease, diabetes mellitus, failure to thrive, hypertension, benign prostatic hypertrophy, severe advanced dementia, coronary artery disease, hypertension, and gastroesophageal reflux disease, and history of sacral PU. R63's admission Minimum Data Set (MDS) assessment dated 8/8/11 revealed that the resident was severely impaired for daily decision making, required total assistance of two persons for bed mobility/transfer and was incontinent. In addition, R63 was at risk for developing PU and did not have any PU at the time of this assessment.</p> <p>On 8/8/11, due to changes in R63's mental status, R63 was transferred to the emergency room and on 8/17/11, R63 returned to the facility from the hospital with diagnosis of sepsis.</p>	F314	<p><b>Immediate</b> – Resident R63 who was admitted as a terminal resident lived 19 days at Governor Bacon Health Center; unfortunately the last week of his life he developed a Stage I pressure ulcer to his left hip.</p> <p><b>Identify</b> – At the time of the survey, there were only two residents with pressure ulcers. The RN supervisor reviewed their pressure ulcer care plans and they were complete. The RN supervisor reviewed both residents' charts and assessed that notification of a change in a resident's condition had been completed.</p> <p><b>Systemic</b> – GBHC Nursing Department will monitor and review all pressure ulcer care plans at the weekly Interdisciplinary Care Plan (ICP) meeting.</p> <p>Pressure ulcer procedures/guidelines will be developed and implemented.</p> <p>GBHC will provide in-service training for staff on the pressure ulcer procedures/guidelines. The in-service will be attended by all Nurses. GBHC will purchase a presentation from the National Pressure Ulcer Board.</p> <p><b>Monitoring</b> – GBHC Nursing Department will develop a quality indicator to track compliance with this issue. The documentation will be submitted and reviewed at the Quality Assurance Committee meetings quarterly.</p>	<p>Resident died on 8/24/11</p> <p>10/21/11</p> <p>10/21/11 and ongoing</p> <p>11/18/11</p> <p>11/21/11 to 12/16/11</p> <p>11/22/11 and ongoing</p>

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F 314	<p>Continued From page 15</p> <p>An interview with the Director of Nursing/DON (E2) on 10/19/11 at approximately 1 PM revealed that the facility did not have a policy and procedure for pressure ulcer management including staging, however, the facility utilized the Lippincott Manual of Nursing Practice, 9th edition, section titled pressure ulcer, pages 186-188. E2 related that all PU are assessed by a Registered Nurse/RN and that the facility documented the assessment on the "Pressure Ulcer Record ." E2 related that upon identification of a new PU, although not a written procedure, the expectation was that the attending physician, dietician, resident's responsible party, and the designated wound management point of contact, E9 (RN Supervisor) would be notified.</p> <p>Review of the above sections of the Lippincott Manual of Nursing lacked the following:</p> <ul style="list-style-type: none"> <li>- The referenced staging system by National Pressure Ulcer Advisory Panel (NPUAP) failed to include suspected deep tissue injury.</li> <li>- The information failed to include a system/procedure to initiate when a new PU was identified.</li> </ul> <p>Review of the readmission nurse's note (N.N.) by E8 (Staff Registered Nurse/RN) dated 8/17/11 timed 2:50 PM documented "...blister to (L) left lateral ankle area measuring 1.1 W (width) x (by) 1.2 L (length), area is purple in appearance and to be left open to air. Resident with (2), stage II areas to sacrum noted... Site #1 located on (R) right upper buttock measures 0.4 (W) x 0.5 (L) x less than 0.1 in diameter (D) with no odor or drainage. Site #2 located on upper sacral crease measuring .8 (W) x .7 (L) x less than .1 (D). Record review lacked evidence that the dietician or R63's responsible party were notified of these</p>	F 314		
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F 314	<p>Continued From page 16 new PUs.</p> <p>Review of R63's " Pressure Ulcer Record" form utilized to document PU included the staging system that was in place prior to February 2007. In February 2007, the NPUAP revised the staging system which included two additional categories of unstageable and suspected deep tissue injury. R63's PU were documented on the form as follows:</p> <p>-8/17/11 stage II of the sacral crease measuring .7 (L), .8 (W), and less than .1 cm. in depth with no drainage or odor.</p> <p>-8/17/11 stage II of the right upper sacrum measuring .5 (L), .4 (W), and less than .1 cm. in depth with no drainage or odor.</p> <p>Record review lacked evidence of staging of the left lateral ankle blister.</p> <p>Subsequent N.N. dated 8/18/11 timed 3 PM documented that the left ankle blister was opened and measured 1.2 (W) x 1.3 (L) x .2 (D). The area had what appeared to be eschar covering approximately 25% of the area.</p> <p>A new "Pressure Ulcer Record" was initiated on 8/19/11 for the left ankle PU as follows:</p> <p>8/19/11 stage II of the left malleolous measuring 1.3 (L), 1.2 (W), and less than .2 cm. (D) with no drainage or odor.</p> <p>N.N. dated 8/19/11 timed 11:30 AM documented "P.T. (physical therapy) and dietary consults complete for (3) stage II pressure ulcers..."</p> <p>An interview with E8 on 10/19/11 at approximately 3 PM revealed that she consulted with the charge nurse to determine the stage of the above PUs.</p>	F 314		
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F 314	<p>Continued From page 17</p> <p>Review of undated "Consultation Request Form" for "dietary" revealed that the physician signed the request form, however, the Registered Dietician/RD, E16 documented "resident expired" and signed on 8/25/11. Although the E16 consultation was initiated on 8/19/11, the facility failed to ensure that this consultation was completed. On 8/24/11, R63 expired.</p> <p>An interview with E16 on 10/20/11 at approximately 10 AM revealed that she attempted to complete the consultation within one to two days, however, she was uncertain when she received this consultation. In addition, E16 was out of the facility from 8/22/11 through 8/24/11.</p> <p>An interview with E9 on 10/20/11 at 11:30 AM revealed that she was the designated point of contact for monitoring PU within the facility and although not written procedure, she was to be notified when a new PU was identified. E9 verbalized that upon notification, she ensured that the necessary consultations were initiated such as dietary and therapy, however, notification of the attending physician and the family member currently was not required. E9 related that during the survey, it was revealed that the staging system on the "Pressure Ulcer Record" failed to include the current staging system. E9 did confirm that she was made aware of the three PU identified upon R63's readmission on 8/17/11, however, was not informed of the left hip PU observed on 8/20/11.</p> <p>N.N. dated 8/20/11 timed 3:45 AM documented "dark purple discolored area observed to left hip-4.5 cm. (L) x 2.2 cm. (W)-skin intact. Perimeter of discolored area present with some</p>	F 314		
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F 314	Continued From page 18 non blanchable erythema. Area offloaded."  A new "Pressure Ulcer Record" was initiated on 8/20/11 for the left hip PU as follows: 8/20/11 stage I of the left hip measuring 4.5 cm. (L) x 2.2 cm. (W) with no depth, drainage or odor.  Record review lacked evidence that the attending physician, dietician or R63's responsible party was notified of this new PU of the left hip.  Review of the significant change MDS assessment dated 8/22/11 revealed presence of one, stage I PU; two, stage II PU; and one, unstageable PU with slough and/or eschar which was present at the time of readmission.	F 314		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced by: Based on observations and hot water temperatures taken in the residents' rooms, it was determined that the facility failed to provide an environment free of accident hazards. Findings include:  1. Room 110 had a hot water temperature of 115.4 degrees Fahrenheit (F) at 9:52 AM on	F323	<b>Immediate</b> – The GBHC Maintenance Department corrected the following: 1 through 5. The water temperatures were immediately corrected. 1, 3, and 5. A purchase requisition was written for the light shields.  <b>Identify</b> – A sweep of the facility was made by Maintenance to determine if there were other related issues.  <b>Systemic</b> – The GBHC Facilities Management Department will do: 1. The water temperatures at the source will be checked daily and logged. The water temperatures at the resident faucets will be checked systematically, which consists of two resident faucets on each nursing unit per week, a total of 6 per week, thus allowing for a quarterly check on each resident faucet. 2. An environmental audit will be conducted on a monthly basis by Facility Management to identify maintenance issues such as the lights and work orders will be submitted.  <b>Monitoring</b> - The water temperature logs and the environmental audits will be submitted to the Quality Assurance Administrator monthly and reviewed at the Quality Assurance Committee meetings quarterly.	10/12/11 11/3/11 10/12/11 to 10/13/11 10/12/11 and ongoing 12/1/11 12/1/11 and ongoing



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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 20 prepare and store food under sanitary conditions. Findings include:  1. Initial tour of the kitchen on 10/11/11 at 10 AM revealed the following:  -The chest freezer in the dry storage room had no thermometer and no temperature log. -The four door freezer had no thermometer but did have a temperature log. This freezer contained a bag of open potatoes, a bag of open peas and a box of corn on the cob that were not labeled with open dates. -The walk in freezer had an open bag of chopped celery with no open date.  2. On 10/18/11 at 10:05 AM, the North 2 unit pantry contained a Maytag-brand refrigerator that had an internal temperature of 56.0F. This was the minimum temperature reached after 15 minutes of recovery time for the refrigerator. The October 2011 temperature log for this refrigerator indicated that the daily temperatures were above the maximum of 41F on thirteen out of seventeen days recorded. This unit was used to store food for the residents on the unit.  3. At 11:10 AM, on 10/20/11, one out of four small steam table pans reviewed in the main kitchen and four out of nine large steam table pans reviewed, had food debris on the food contact surfaces. These pans were stored as ready-to-use on the clean pots and pans shelving unit.  4. On 10/12/11, at 10:50 AM, the ice scoop on the North 2 unit hydration cart was lying on top of the water cooler. This was not a sanitary manner of	F 371	Systemic – 1 and 3. GBHC will hire dietary supervisors to ensure that deficient practices do not recur. GBHC Dietary staff will be trained in the importance of recording and addressing temperatures, labeling of food items, cleanliness, etc. 2. Nursing will continue to monitor the North 2 resident refrigerator. The refrigerator will be replaced by purchasing a new one. A sweep will be done to see if there are other affected refrigerators. 4. A new holder will be ordered for the ice scoop for North 2 and Nursing will ensure that ice scoop is properly placed in holder when scoop is not in use.  Monitoring – 1 and 3. Temperature logs, labeling, cleanliness, and other daily work flows will be monitored by Dietary supervision and reviewed by the Dietary Director. 2. Nursing will continue to monitor the North 2 resident refrigerator and submit documentation to RN supervisors. 4. Nursing will ensure that the ice scoop is placed in the holder when not in use. For 1 through 4, the documentation will be submitted to the Quality Assurance Administrator on a monthly basis and will be reviewed by the Quality Assurance Committee quarterly.	11/1/11 and ongoing  11/15/11 to 12/5/11 10/21/11 12/1/11 11/30/11  10/20/11 and ongoing

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

PRINTED: 10/31/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  08E029	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  10/20/2011
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F 371	Continued From page 21 storing a food handling utensil. On 10/18/11, at 10:55 AM, this observation was made again.	F 371		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.  (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (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.  (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of	F441	<b>Immediate</b> - The LPN was instructed in proper hand washing per GBHC Hand Washing Protocol.  <b>Identify</b> - This could affect all residents. RN supervisors reviewed with staff proper handing washing per GBHC Hand Washing Protocol.  <b>Systemic</b> - GBHC Nursing Department will monitor staff for proper handing washing per GBHC Hand Washing Protocol.  GBHC will provide an additional in-service to refresh staff in proper hand washing per GBHC Hand Washing Protocol.  <b>Monitoring</b> - GBHC Nursing Department will develop a quality indicator to track compliance with this issue. It will be submitted and reviewed at the Quality Assurance Committee meetings quarterly.	10/12/11  10/12/11 and ongoing  10/21/11 and ongoing  11/16/11 to 12/16/11  11/22/11 and ongoing

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NAME OF PROVIDER OR SUPPLIER  <b>GOVERNOR BACON HEALTH CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE P.O. BOX 559 <b>DELAWARE CITY, DE 19706</b>
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F 441	Continued From page 22 infection.  This REQUIREMENT is not met as evidenced by: Based on observation and review of the facility's policy and procedures it was determined that the facility failed to use proper infection control measures by failing to wash hands as indicated in the facility's policy and procedure. Findings include:  Review of facility's policy and procedure titled "Employee Handwashing Procedure" noted for "steps in hand washing" - "7. Wipe hands dry with paper towel in a wrist to fingertip direction, use clean paper towel..." - "8. Close off faucet with towel you dried your hands..."	F 441		
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH  The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities.  This REQUIREMENT is not met as evidenced	F463	<b>Immediate</b> – The 107A call bell was fixed on 10/12/11 and 10/19/11.  <b>Identify</b> – Nursing conducted a sweep of the facility to ensure that call bells were working properly.  <b>Systemic</b> – Nursing, in conjunction with Facilities Management, will check call bells and call bells that are defective will be reported to Maintenance for repair.  <b>Monitoring</b> – A report will be submitted monthly to the Quality Assurance Administrator and will be reviewed by the Quality Assurance Committee quarterly.	10/12/11 and 10/19/11 10/12/11 to 10/13/11  10/19/11 and ongoing  11/1/11 and ongoing

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F 463	Continued From page 23 by: Based on observations made in resident rooms during the survey, it was determined that the facility failed to have a functioning call system in resident rooms. Findings include:  1. On 10/12/11, at 11:40 AM, the A-bed call bell of room 107 would not remain activated when squeezed. It would ring once and would not remain on. On 10/19/11, at 11:50 AM, the same observation was made.	F 463			
F 490 SS=D	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING  A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.  This REQUIREMENT is not met as evidenced by: Based on record review, interviews, and other facility documentation, it was determined that the facility was not administered in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable level of well-being of each resident. Findings include:  Cross refer F314. The facility failed to ensure that the existence of a system/procedure for PU prevention and management which included notification of R63's attending physician, resident's responsible party, dietary, and therapy consultation was utilized.	F490	<b>Immediate</b> – Resident R63 who was admitted as a terminal resident lived 19 days at Governor Bacon Health Center; unfortunately the last week of his life he developed a Stage I pressure ulcer to his left hip.  <b>Identify</b> – At the time of the survey, there were two residents with pressure ulcers. The RN supervisor reviewed both residents' charts and assessed that notification of a change in a resident's condition had been completed.  <b>Systemic</b> – GBHC Nursing Department will monitor and review notification of the physician, dietitian and legal representative of any resident who develops a pressure ulcer at the weekly Interdisciplinary Care Plan (ICP) meeting.  Pressure ulcer procedures/guidelines will be developed and implement.  GBHC will provide in-service training for staff on the pressure ulcer procedures and guidelines including notification of the physician, dietitian and legal representative of any resident with changes such as a pressure ulcer. This in-service will be attended by all nurses.  <b>Monitoring</b> – GBHC will develop a quality indicator to track compliance with this issue. The documentation will be submitted and reviewed at the Quality Assurance Committee meetings quarterly.	Resident died on 8/24/11  10/21/11  10/21/11 and ongoing  11/18/11  11/21/11 to 12/16/11  11/22/11 and ongoing	



**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

Page 1 of 2

NAME OF FACILITY: Governor Bacon Health Center

DATE SURVEY COMPLETED: 10/20/11

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
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<p>3201</p> <p>3201.1.0</p> <p>3201.1.2</p>	<p><b>The State Report incorporates by reference and also cites the findings specified in the Federal Report.</b></p> <p>An unannounced annual survey and was conducted at this facility from October 11, 2011 through October 20, 2011. The deficiencies contained in this report are based on observation, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was eighty-one (81). The survey sample totaled twenty-nine (29) residents.</p> <p><b>Skilled and Intermediate Care Nursing Facilities</b></p> <p><b>Scope</b></p> <p><b>Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.</b></p> <p><b>This requirement was not met as evidenced by:</b></p>	
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Provider's Signature  Title Director Date 11/14/11



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	<p>Cross refer to the CMS 2567-L survey report date completed 10/20/11, F157, F225, F241, F253, F279, F309, F314, F323, F371, F441, F463 and F490.</p>	<p>State 3201</p> <p>Cross-reference to the CMS 2567-L survey report date completed on 10/21/11, F157, F225, F241, F253, F279, F309, F314, F323, F371, F441, F463, and F490.</p>
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