



**DELAWARE HEALTH
AND SOCIAL SERVICES**

DSAAPD

LONG TERM CARE

December 2, 2015

Mr. Robert H. Smith
Licensing and Certification Administrator
DHSS/LTCRP
3 Mill Road, Suite 308
Wilmington, DE 19806

Dear Mr. Smith:

Enclosed is the Plan of Correction for the Annual Survey for Governor Bacon Health Center conducted in October 2015. Thank you for giving us an extension until December 2, 2015 to respond. As per the instructions in your letter, the GBHC plan of correction includes the following:

- Identified the corrective actions for those residents affected by the deficient practice;
- Listed the steps taken by GBHC to identify other residents having the potential to be affected by the same deficient practice;
- Described the measures that will be put in place to ensure that the deficient practice does not recur;
- Identified how GBHC plans to monitor our corrective action plan for each deficiency to achieve success.

Governor Bacon Health Center (GBHC) is submitting the Plan of Correction as written credible allegation of compliance for correcting the deficiencies found during the survey. I thank the members of the survey team for their efforts identifying areas where GBHC was non-compliant with the regulations for nursing facilities. Their findings will help GBHC staff maintain high standards of care and provide opportunities for improvement in the services we offer to our residents.

If you have any questions or need additional information, please feel free to call me at (302) 836-2335.

Sincerely,

A handwritten signature in black ink, appearing to read "Lois M. Quinlan".

Lois M. Quinlan, PhD, LNHA
Director

Attachments: Completed Statement of Deficiencies/Plan of Correction - Form CMS-2567L
Completed State Survey Report

cc: John Oppenheimer, LTC Section Chief

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

PRINTED: 11/16/2015
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 C 10/28/2015
NAME OF PROVIDER OR SUPPLIER GOVERNOR BACON HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 248 KENT AVE DELAWARE CITY, DE 19706	
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F 000	<p>INITIAL COMMENTS</p> <p>An unannounced annual and complaint survey was conducted at this facility from October 20, 2015 through October 28, 2015. The deficiencies contained in this report are based on observation, interviews, and review of residents' clinical records and other facility documentation as indicated. The facility census the first day of the survey was seventy-one (71). The survey sample totaled thirty-five (35).</p> <p>Abbreviations/Definitions used in this 2567 are as follows: NHA - Nursing Home Administrator; DON - Director of Nursing; ADON - Assistant Director of Nursing; RN - Registered Nurse; LPN - Licensed Practical Nurse; UM - Unit Manager; MD - Medical Doctor; RNAC - Registered Nurse Assessment Coordinator; CNA - Certified Nurse's Aide; FSD - Food Service Director; RD - Registered Dietitian; NP - Nurse Practitioner; PA - Physician Assistant; QA - Quality Assurance; ADLs - Activities of Daily Living, such as bathing and dressing; PRN - As needed; MAR - Medication Administration Record (on paper); TAR - Treatment Administration Record (on paper); eMAR - Electronic Medication Administration Record (in the computer); EMR - Electronic Medical Record;</p>	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* PND, LNHA *[Signature]* Director TITLE *[Signature]* 12/2/15 (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 MDS - Minimum Data Set (standardized assessment used in nursing homes); ROM - Range of motion, extent to which a joint can be moved safely; HS - At bedtime; cm - cubic centimeters (unit of measurement); GDR - gradual dose reduction; NADS - nurse aide data sheets; Antipsychotic - drug to treat psychosis and other mental/emotional conditions; Anxiety - general unpleasant state of feeling worry, nervous or restless; Ativan - medication used to treat anxiety; Blood Pressure - measure of the force of the blood against the walls of a blood vessel; Cancer-disease characterized by rapid growth of abnormal cells in the body; Callus - hard, thick skin, if not trimmed, becomes very thick and can turn into an open sore; Charcot foot - deformity of weight bearing joints in foot due to peripheral neuropathy, increasing chance for diabetic ulcers; Diabetes- disease where sugar levels are too high; Diabetic ulcers-wounds that develop as complications from diabetes; Dementia - severe state of cognitive impairment characterized by memory loss, poor judgement, disorientation and personality changes; Dialysis - cleaning of blood by artificial means when kidneys have failed; Dysphagia - difficulty swallowing; Incontinent - loss of control of bladder and/or bowel function; Kidney disease-loss of kidney function to filter the blood by removing waste; Meal set up - place meal and utensils on table, uncover containers, add condiments and cut up food to prepare for eating;	F 000			

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F 000	Continued From page 2 med-medication; Mobility - move about freely; Peripheral neuropathy - nerve damage causing tingling, pain, weakness, or loss of feeling in the feet/hands; Plantar foot - bottom of the foot; Pressure ulcer-sore area of skin that develops when blood supply to it is cut off due to pressure; Psychosis/psychotic - loss of contact with reality; Pulse - the number of times the heart beats in one minute; Seroquel - anti-psychotic medication; Type 1 diabetes - disease occurring in children and young adults where body does not make any insulin leading to high blood glucose (sugar); Xanax - medication used to treat anxiety.	F 000		
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R42) out of 35 sampled residents the facility failed to implement their policy for resident protection after an allegation of sexual abuse. Findings include: The facility's policy memorandum entitled "Protection from Abuse and Responding to Reportable Incidents", last approved on June 1, 2015, indicated "any employee suspected of	F 226	<u>Individual Resident Impacted</u> GBHC failed to implement their policy for resident protection after an allegation of sexual abuse. The alleged staff member wasn't reassigned for the duration of the investigation. Employee no longer works at GBHC. <u>Identification of Other Residents with Potential to be Affected</u> All the residents of GBHC have the potential to be affected. Review of resident records didn't reveal any other reports of abuse.	12/22/15

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F 226	<p>Continued From page 3</p> <p>committing any of these acts will be reassigned for the safety of the resident's for the duration of the investigation."</p> <p>Review of clinical records and facility documents for R42 and R33 revealed the following;</p> <p>A nurse's progress note, dated 7/8/15 written by E6 (RN Quality Supervisor) documented an allegation of abuse concerning R42.</p> <p>On 7/8/15 through 7/30/15 an investigative process was in progress, with E5 (Q A Administrator) designated as the investigator in what was documented as an incident of "sexual abuse". In the description of the incident it was documented that "R33 alleged that she saw E8 CNA rubbing R42's breast. R33 told E8 to stop, but "he kept doing it".</p> <p>During an interview on 10/26/15 at 2:18 PM with E6 (RN Quality Supervisor) it was confirmed that, E8 continued to work as a CNA during his next scheduled shift after the beginning of the investigation and E6 provided the surveyor with a copy of E8's schedule for the duration of the investigation into the allegation of abuse.</p> <p>Review of the shift summary assignments listed E8's work assignments from 7/8/15 through 7/30/15 indicated E8 continued to be assigned to patient care during the course of the investigation; specifically assigned to patient care on 7/9, 7/10, 7/13, 7/17, 7/18, 7/19, 7/21, 7/23, and 7/27/15.</p> <p>During an interview on 10/27/15 at 10:09 AM with E2 (DON) it was reported that when the allegation was made, E8 wasn't named. The description</p>	F 226	<p><u>System Changes</u></p> <p>Root Cause</p> <p>1) Failure by Nursing management to complete the initial incident report. GBHC Educator will complete training of supervisors and other RNs on the following: abuse prevention policy, incident report completion and reasonable suspicion of a crime. This training will also continue to be done annually in our mandatory in-service for all staff.</p> <p>2) Miscommunication and misunderstanding in reviewing the employee statements and investigative report.</p> <p>To prevent this from happening again we will review as a team, at a minimum QA, DON and RN Supervisor.</p> <p>All investigations will again be reviewed weekly in our incident report meeting to ensure nothing was missed.</p>	

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F 226	Continued From page 4 was a person with a maroon uniform. When E5, got in depth into the investigation it came out, that E8 was the accused. E2 confirmed that "usually that would be our routine" to remove an accused employee from patient care during the course of an investigation. Simultaneous interviews took place with E2 and E5 on 10/27/15 at 11:34 AM. E5 stated " [name of] E8 didn't go back and work with [names of] R42 or R33". We didn't put E8 in the kitchen (removing him from patient care) because we didn't truly believe this was something that happened. E8 did not work with residents on the unit in which the alleged incident took place. E2 indicated that when details of the allegation began to arise, such as E8's possible involvement, due to R33's care plan for false accusations the supervisors made a judgement call and E8 was not removed from patient care. These findings were reviewed with E2 (DON), E5 (QA Administrator) and E6 (QA Supervisor) on 10/28/15 at 2:30 PM.	F 226 Success Evaluation	<u>Success Evaluation</u> This will be reviewed at least weekly by the RN Supervisors for twelve (12) weeks or until the facility reaches 100% success over 8 consecutive evaluations. We will then conduct bi-weekly audits until we reach 100% success at three (3) consecutive evaluations. Finally, we will measure practices one (1) month later. If facility is still compliant, then we conclude that we have successfully addressed the problem. These findings will be reviewed at the monthly Quality Assurance Committee meetings (QAPI).		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation it was determined that for 18 (R1, R11, R13, R21, R26, R29, R31, R33, R37, R42, R55, R57, R73, R24, R6, R62, R15,	F 241 Individual Resident Impacted	It is GBHC's goal to provide dining in a manner that enhances dignity. On two (2) out of three (3) dining times, drinks served were either not opened or served in cartons, without a straw or clean cup in which to pour the liquid.	12/2/15	

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F 241	Continued From page 5 R53) out of 35 sampled residents, the facility failed to provide dining in a manner that enhanced dignity on 2 out of 3 dining areas. Drinks served were either not opened or served in cartons, without a straw or clean cup in which to pour the liquid. Findings include: 1. 10/20/15 - Lunch observation on North 1 day room between 12:10 PM - 12:35 PM a. R1 was served a cup of juice with a foil lid by E11 (FSD) who opened the carton of milk and proceeded to serve the next table. The resident struggled to open the juice container since he has difficulty moving one arm. R1 stuck his fork through the foil of the juice cover several times before making a hole large enough to drink through. b. Thirteen (R1, R11, R13, R21, R26, R29, R31, R33, R37, R42, R55, R57, R73) of the 21 residents dining were served milk and lemonade in cardboard cartons without a straw and the liquid was not poured into a cup. c. R24 poured his/her own milk product into the juice cup after drinking the juice because no other cup was provided. 2. During dining observation on 10/20/15 between 12:30 PM - 1:15 PM in the South 1 day room, 4 (R6, R62, R15, R53) out of 18 residents were observed drinking directly from their milk & lemonade cartons because no cups or straws were provided. These findings were reviewed with E2 (DON), E5 (QA Administrator) and E6 (QA Supervisor) on 10/28/15 at 2:30 PM.	F 241 Identificat ion of other residents having the potential to be affected Systemic Changes Success Evaluatio n)	All 71 residents during mealtimes have the potential to be affected. Dietary supervisors will ensure dietary staff provides clean cups and straws at meal times. Dietitian and Nursing staff will work with all residents on their preference during meal times of either cups or drinking from a carton with a straw. Trainer/educators will complete an in-service on dining with dignity for all staff. Individual responsible for Action: GBHC Dietary Supervisors and nurse in charge will monitor each meal to ensure clean cups are provided and that cartons are opened and a straw is provided at every meal. This will occur for four (4) weeks or until 100% compliance is achieved over three (3) consecutive evaluations. Next they will conduct monthly audits until we have achieved 100% success. Finally they will conduct audits one (1) more time a month later. If 100% compliance is achieved, then we will conclude that we have successfully addressed the problem. These findings will be reviewed at the monthly QAPI meetings.		

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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 observation and interview it was determined that the facility failed to ensure the necessary housekeeping and maintenance services necessary to maintain a comfortable interior in 1 (North 2) out of 3 shower rooms and 9 (122, 127, 130, 132, 134, 139, 205, 208, and 216) out of 16 resident rooms. Findings include:</p> <ol style="list-style-type: none"> 1. During the initial tour on 10/20/15 between 10:30 AM and 11:00 AM the following were observed: <ol style="list-style-type: none"> a. North 2 shower room: scraped paint and rust on lower section of main entrance door frame and door frame of toilet room. b. North 2 shower room: rusty vent cover on wall-mounted heaters in toilet room, tub room and main room by shower. Scraped paint and rust on lower section of main entrance door frame. Broken shower hose head holder with rusted screws in the front shower. c. Storage area North 1: Sit to stand lifts #1 and #5 with scraped and rust on legs and lift belt with tan/white stain around 5 inches in width on the middle of the outside. d. Air conditioner/heater (across from North 1 day room): top with worn paint and rust. e. Storage area South 1 (across from room 127): smelled of urine in the vicinity of 8 wheelchairs. f. Exit door at end of hallway on South 1 near room 133: was opened 10-12 inches before 	F 253	<p>GBHC regrettably acknowledges that some areas were not maintained in a manner to sustain comfort and a pleasing appearance.</p> <p>All 71 residents living at GBHC have the potential to be affected.</p> <p><u>Monthly:</u></p> <ol style="list-style-type: none"> 1. Maintenance will do a sweep to identify and repair all the bathrooms shower doors, shower hose heads, and hall way air conditioner units for rust. 2. Maintenance will do a room to room walk thru on all units to identify and repair rooms with damage to walls, furniture and doors. <p><u>Daily</u></p> <ol style="list-style-type: none"> 1. Materials Management will check and replace all lift belts for cleanliness and stains. Work orders to Maintenance will be done for any areas showing rust. 2. Housekeeping will monitor and clean storage areas where wheel chairs are stored. 3. Power Plus technicians will evaluate and adjust the door sensors on exit doors for increased sensitivity when opened. 4. Maintenance/Nursing will check all pull cords for proper placement for residents. <p>1. PSC company was called in and a quote obtained to replace all rusty vent cover on wall heaters in the toilet rooms, tub and main shower rooms.</p>	12/10/15	

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F 253	Continued From page 7 alarm sounded at the nursing station. 2. The following observations were made during Stage 1, 10/20/15 to 10/22/15 (9:00 AM to 3:00 PM) and on 10/23/15 from 10:30 - 11:00 AM: - 1 (134) out of 16 rooms had a pull cord for the over the bed light that was too short and not accessible to the residents; - 4 (127, 205, 208, and 216) out of 16 rooms had wall damage; - 5 (122, 127, 139, 205, and 216) out of 16 rooms had baseboards in disrepair; - 2 (130 and 132) out of 16 rooms had furniture in need of repair; - 2 (130 and 132) out of 16 rooms had damaged doors. Findings were reviewed and confirmed by E17 (Housekeeping Supervisor) and E18 (FMD) on 10/28/15 during an environmental tour from 10:11 - 10:41 AM. These findings were reviewed with E2 (DON), E5 (QA Administrator) and E6 (RN Quality Supervisor) on 10/28/15 at 2:30 PM.	F 253	<u>Weekly</u> Risk Manager will also do weekly environmental checks and work orders will be submitted to Maintenance for repairs if any shorten pull cords, rusted equipment or doors and any damage to rooms or furniture as required. A maintenance mechanic will be assigned to each nursing unit for weekly inspection and repairs. Risk Manager will do weekly environmental checks on all nursing units. This will occur for four (4) weeks or until 100% compliance is achieved over three (3) consecutive evaluations. Next they will conduct monthly audits until we have achieved 100% success. Finally they will conduct audits one (1) more time a month later. If 100% compliance is achieved, then we will conclude that we have successfully addressed the problem. Maintenance & Risk Manager will submit their findings to be reviewed at the monthly QAPI meetings.		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE 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 resident assessment instrument (RAI) specified by the State. The assessment must include at	F 272	<u>Individual Resident Impacted</u> The facility failed to ensure the comprehensive assessment was accurate for 1 (R57) out of 35 sampled residents. The annual MDS did not include dementia or psychosis under active diagnosis. The N-1 unit Charge Nurse addressed the MDS corrections. The annual MDS was too late to change.	12/22/15	

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F 272	Continued From page 8 least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to ensure the comprehensive assessment was accurate for 1 (R57) out of 35 sampled residents by not including several active diagnoses. Findings include: 6/13/14 - Review of the medical record found R57	F 272 Identificati on of Other Residents with Potential to be Affected System Changes	<u>Identification of Other Residents with Potential to be Affected</u> All other residents have the potential to be affected. The RN supervisor and Charge Nurses reviewed all recent annual MDS for having an accurate list of all active diagnoses. After reviewing by the Charge Nurses and Nursing QA this was an isolated case. <u>System Changes</u> One annual MDS assessment period failed to capture all the resident active diagnoses. The MDS form for each resident is completed by one of three Charge Nurses. The root cause was failure to enter/identify correct data for the MDS. To ensure the accuracy of MDS coding the facility: 1) Nursing Administration reviewed with the Charge Nurses accurate coding of MDS which includes recording all active diagnoses on the annual assessment. 2) When completing the MDS the Charge Nurses and Nursing QA will compare the list of active diagnoses to the resident's history & physical and to the Physician ordering sheet (POS) for any new diagnosis. Nursing Administration QA and the Charge Nurses will meet once a week to review each completed MDS for coding diagnoses accurately. Any changes from the previous MDS will	

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F 272	Continued From page 9 admitted with diagnoses including diabetes with chronic kidney disease, dementia and psychotic disorder. 12/2/14 - Care plan included a problem of altered thought process: dementia with psychotic features 6/22/15 - Annual MDS did not include dementia or psychosis under active diagnoses. Interview 10/27/15 at 11:05 AM with E6 (RN, UM) confirmed the diagnoses were not recorded in the assessment. These findings were reviewed with E2 (DON), E5 (QA Administrator) and E6 (QA Supervisor) on 10/28/15 at 2:30 PM.	F 272 Success Evaluation	be reviewed thoroughly. This will allowed a second review before submitting the MDS forms. <u>Success Evaluation</u> Individual responsible for Action: GBHC's Nursing Administration QA and/or RN supervisor will conduct audits of completed MDS forms for accuracy. All completed MDS forms will be evaluated for accuracy weekly for twelve (12) weeks or until the facility reaches 100% success over 8 consecutive evaluations. We will then conduct bi-weekly audits until we reach 100% success at three (3) consecutive evaluations. Finally, we will measure practices one (1) month later. If facility is still compliant, then we conclude that we have successfully addressed the problem. These findings will be reviewed at the monthly Quality Assurance Committee meetings (QAPI).		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is	F 278			

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F 278	<p>Continued From page 10</p> <p>subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for 3 (R7, R57, and R4) out of 35 sampled residents the facility failed to ensure the accuracy of the MDS assessment. Findings include:</p> <p>1. 10/11/00 - A pre-admission screening level II review indicated R7 was considered blind.</p> <p>6/28 and 9/29/15 - R7's quarterly MDSs documented impaired vision (sees large print, but no regular print in newspapers/books) with no corrective lenses.</p> <p>10/26/15 11:18 AM - Interview with E9 (RN, UM) revealed that R7's vision assessment was the ability to follow a large object and should have been coded as highly impaired (object identification in question, but eyes appear to follow objects). E9 confirmed the MDS was coded inaccurately.</p> <p>Cross Refer F279, Example 2. 2. 6/13/14 - R57 admitted with diagnoses including poorly controlled Type 1 diabetes with</p>	<p>F 278</p> <p>Individual Resident Impacted</p> <p>Identification of other residents having the potential to be affected</p> <p>Systemic Changes</p>	<p>Individual Resident Impacted</p> <p>The facility failed to ensure the accuracy of the quarterly MDS assessment for three residents. 1) R7 - MDS section B (Vision), 2) R57 - MDS section M (Skin Condition/diabetic wound) 3) R-4 - MDS section B (Speech).</p> <p>Identification of Other Residents with Potential to be Affected</p> <p>All residents have the potential to be affected. The Charge Nurses are reviewing all recent MDS Sections B (vision/speech) and M (Skin Conditions). No other issues found.</p> <p>System Changes</p> <p>The root cause was failure to enter/identify correct data for the MDS. To ensure the accuracy of MDS coding the facility: 1) Nursing Administration reviewed with the Charge Nurses the importance of accurate coding of MDS which includes Sections B & M. (Cross reference F279) 2) Before Section M of the MDS is submitted, it will be reviewed by the Designated Wound Care Nurse. 3) During the residents Interdisciplinary Care Conference, we will review Section B (Vision, hearing & speech). This will assist the Charge Nurse in accurate MDS documentation.</p>	12/22/15

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F 278	<p>Continued From page 11 peripheral neuropathy.</p> <p>7/9/15 Wound Consult - plantar left foot callus, wound not open, charcot foot.</p> <p>9/16/15 - Pressure ulcer record showed the resident with two wounds to the left foot (ankle and plantar area).</p> <p>9/25/15 - Quarterly MDS skin condition section documented the resident had pressure ulcers.</p> <p>10/5/15, 10/12/15 and 10/19/15 - Wound evaluation form recorded foot wounds (ankle and plantar) as diabetic ulcers.</p> <p>10/27/15 - Interview at 10:50 AM with E9 (Charge Nurse, North 1) confirmed the medical record documented the resident had two foot pressure ulcers. It is not clear why the medical record still reflected the wrong type of wound for R57 since the wound evaluation forms were reviewed by the nurse. E9 stated she would change the documentation to reflect diabetic ulcers.</p> <p>The facility failed to ensure the accuracy of this quarterly MDS by documenting R57 had pressure ulcers instead of diabetic ulcers.</p> <p>3. The MDS dated 5/17/15 and 8/18/15 for Section B documented R4's speech as clear speech-distinct intelligible words.</p> <p>A note from Social Services dated 8/14/15 stated: attempted to interview resident for MDS 3.0, Section D but resident just sat making grunting sounds and swung his extended leg at the worker. Unable to do mood assessment. There were no major changes or concerns otherwise.</p>	F 278 Success Evaluation	<p><u>Success Evaluation</u></p> <p>This will be reviewed by the RN Supervisors at least weekly for twelve (12) weeks or until the facility reaches 100% success over 8 consecutive evaluations. We will then conduct bi-weekly audits until we reach 100% success at three (3) consecutive evaluations. Finally, we will measure practices one (1) month later. If facility is still compliant, then we conclude that we have successfully addressed the problem. These findings will be reviewed at the monthly Quality Assurance Committee meetings (QAPI).</p>	

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F 278	Continued From page 12 Interview with E12 (LPN) on 10/28/15 at 10:07 AM stated that the resident occasionally will say "no" but does not use intelligible words and has been like this for at least a year. E12 (LPN) confirmed that the MDS was coded incorrectly. The facility failed to accurately complete quarterly MDS assessments for three residents. These findings were reviewed with E2 (DON), E5 (QA Administrator) and E6 (QA Supervisor) on 10/28/15 at 2:30 PM.	F 278			
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 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).	F 279 Individual Resident Impacted Identification of other residents having the potential to be affected	<u>Individual Resident Impacted</u> The facility failed to ensure a care plan was developed for an identified resident need. 1) R. 10 was re-started on an antipsychotic medication, but the facility did not initiate a care plan for the medication and the behaviors associated with its use. 2) The facility did not initiate a care plan for R57's diabetic ulcer and inaccurately continued with the pressure ulcer care plan. <u>Identification of Other Residents with Potential to be Affected</u> All residents re-starting an antipsychotic or having any type of ulcer have the potential to be affected. Review of the resident records revealed these were isolated cases.	12/22/15	

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F 279	<p>Continued From page 13</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for 2 (R10 and R57) out of 35 sampled residents the facility failed to ensure a care plan was developed for an identified need. Findings include:</p> <p>1. Cross- refer F329.</p> <p>R10 was restarted on an anti-psychotic medication on 10/21/15 for undefined behaviors. The facility did not initiate a care plan for the use of this medication and the behaviors associated with its use.</p> <p>10/27/15 2:21 PM - Interview with E14 (RN, UM) revealed that the original care plan for the use of anti-psychotic medication and behavior monitoring had been discontinued on 9/15/15 when the resident was no longer on the medication and was not displaying any behaviors. E14 confirmed that a new care plan was not initiated when the resident was restarted on medications for behaviors.</p> <p>2. Cross Refer F278, Example 2.</p> <p>6/14/13 - R57 admission to the facility with multiple diagnoses including poorly controlled Type 1 diabetes and peripheral neuropathy.</p> <p>9/12/14 - charcot foot added to diagnosis list in medical record.</p> <p>7/9/15 Wound Consult - plantar left foot callus, wound not open, charcot foot.</p> <p>9/23/15 - Care Plan problem revision (initiated</p>	F 279	<p><u>System Changes</u> Root Cause: Cross reference F329 1) The RN following through on the Doctor's order to re-start the antipsychotic medication didn't realize the care plan and behavioral plan had been discontinued. The shift supervisors will meet with staff and review the process in restarting an antipsychotic medication. We must check that the care plan and behavioral plan is in place and updated as appropriate. Cross reference F 278 2) The Designated Wound Care Nurse will review care plan changes and updates for all type of ulcers.</p> <p><u>Success Evaluation</u> This will be reviewed by the RN Supervisors at least weekly for twelve (12) weeks or until the facility reaches 100% success over 8 consecutive evaluations. We will then conduct bi-weekly audits until we reach 100% success at three (3) consecutive evaluations. Finally, we will measure practices one (1) month later. If facility is still compliant, then we conclude that we have successfully addressed the problem. These findings will be reviewed at the monthly Quality Assurance Committee meetings (QAPI).</p>		

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F 279	Continued From page 14 6/14/13) for impaired skin integrity related to pressure ulcer left foot had goal that open area will show evidence of healing such as reduction in size, amount of necrotic (dead) tissue, odor and pain. 10/5/15, 10/12/15, 10/19/15 - Wound evaluation forms identified the left ankle and plantar foot wounds as being diabetic ulcer. The physician (E13) and charge nurse (E9) initials were written at the bottom of all three forms. 10/27/15 - Interview at 11:00 AM with E9 (RN) confirmed the care plan documented the resident had two foot pressure ulcers. E9 stated the initials on the bottom of wound evaluation forms indicated that she and E13 reviewed the form. It is not clear why the care plan still reflected the wrong type of wound for R57 since the wound evaluation forms were reviewed by the nurse. E9 stated she would change the documentation to reflect the diabetic ulcer. The care plan did not accurately reflect R57's diabetic ulcers. These findings were reviewed with E2 (DON), E5 (QA Administrator) and E6 (QA Supervisor) on 10/28/15 at 2:30 PM.	F 279			
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.	F 280 Individual Resident Impacted	<u>Individual Resident Impacted</u> The facility failed to revise the care plan for one (1) resident. The care plan for anxiety listed Xanax, but had been changed by the physician to Ativan. The plan was immediately revised.	12/22/15	

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F 280	<p>Continued From page 15</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to revise the care plan for 1 (R57) out of 35 sampled residents to reflect the resident's current status</p> <p>6/14/13 - R57 admission to the facility with multiple diagnoses including poorly controlled Type 1 diabetes and chronic kidney disease.</p> <p>7/31/15 - Care plan problem for anxiety (printed 9/18/15) included an undated handwritten comment under the evaluation column "Routine Xanax 3 times a week".</p> <p>8/31/15 - Physician order discontinued Xanax and was changed to Ativan for anxiety to be given in the morning prior to dialysis.</p> <p>The care plan was not updated to reflect the change in medication.</p>	F 280	<p><u>Identification of Other Residents with Potential to be Affected</u> All residents receiving an anxiety medication have the potential to be affected. Charge Nurses are reviewed the care plans no other issues found.</p> <p><u>Systemic Changes</u> Root cause: Adding a medication to a care plan without checking with the Medication Administration Record (MAR). 1) Review with Charge Nurses the importance of accurately completing the resident's care plan. 2) The Medication Administration Record (MAR) will be reviewed by the Charge Nurse when completing the resident's care plan, which will prevent missing a change in medication. This will be reviewed by the psychotropic reduction team.</p> <p><u>Success Evaluation</u> This will be reviewed by the RN Supervisors at least weekly for twelve (12) weeks or until the facility reaches 100% success over 8 consecutive evaluations. We will then conduct bi-weekly audits until we reach 100% success at three (3) consecutive evaluations.</p>		

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F 325	Continued From page 17 October 2015 - Physician order sheet included an order for mechanical soft diet with finger foods and nectar thick liquids. Close supervision with meals: feeding assist as needed. 10/23/15 11:55 AM - R65 was observed in the dayroom eating lunch. There was a hot beverage in a mug, a container of lemonade and a carton of chocolate milk in front of the resident unopened. There were no cups provided. R65 asked E6, RN for his chocolate milk. E6 proceeded to open the carton, insert a straw and handed it to the resident. E6 left the area and R65 drank the milk rapidly with some coughing. Moments later E15 (CNA) approached R65 with a second carton of chocolate milk, a cup, a spoon and 2 packages of thickening agent. E15 stated that when asked to get a second carton of milk she checked the NADS to see R65's diet and it noted he was on nectar thick liquids. 10/27/15 10:21 AM - Interview with E16 (RN), and E14 (RN, UM) revealed that the facility used to have a sticker attached to the placemat that included the diet. Currently dietary slips are used to plate the meals but are not kept at the residents' place settings for reference. E14 revealed that the diet list on the unit had not been updated and failed to include R65 who recently moved to the unit. E14 updated the list. 10/28/15 10:14 AM - Interview with E6 confirmed that the chocolate milk provided to R65 was not nectar thick. These findings were reviewed with E2 (DON), E5 (QA Administrator) and E6 (QA Supervisor) on 10/28/15 at 2:30 PM.	F 325	<u>Systemic Changes</u> <u>System Changes</u> Root cause: Not reviewing therapeutic diet documentation. 1) The dietician has been reviewing all diets and updating. 2) The Nursing Assistant Documentation has been reviewed and updated. 3) All diets with thickened liquids have been reviewed. 4) The list of thickened liquids and type has been updated on each unit. Diet changes will be reviewed at our Interdisciplinary Care Plan Meeting. The RN supervisor will keep the Access program diet types updated. The QA Nurse will review thickened fluid diets list in the Access program for accuracy. <u>Success Evaluation</u> This will be reviewed at least weekly by the RN Supervisors for twelve (12) weeks or until the facility reaches 100% success over 8 consecutive evaluations. We will then conduct bi-weekly audits until we reach 100% success at three (3) consecutive evaluations. Finally, we will measure practices one (1) month later. If facility is still compliant, then we conclude that we have successfully addressed the problem. These findings will be reviewed at the monthly Quality Assurance Committee meetings (QAPI).		

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F 329	<p>Continued From page 19</p> <p>Seroquel for the diagnosis of dementia with psychosis.</p> <p>3/10/15 - Care plan for alteration in thought processes dementia with psychotic features that was noted as being discontinued on 9/15/15 because he was no longer on anti-psychotic medication.</p> <p>3/20/15 - Care plan for potential for injury related to resistive behavior noted as being discontinued on 9/15/15 because there were no behaviors.</p> <p>6/14/15 - Progress note from the psychologist documented; In regard to his mental status, the patient was stable. His affect is broad and his mood is "good". He is not psychotic. The attending physician documented in pen on 7/14/15 that a GDR had been started.</p> <p>6/14/15 - Quarterly MDS assessment documented the resident was alert, oriented and independent in decision making.</p> <p>7/14/15 - 8/4/15 - R10 was gradually tapered off and discontinued from the use of Seroquel per MD orders.</p> <p>8/23/15 10:30 PM Nurse's note - Resident has been observed screaming obscenities at staff (CNAs) during care x3. Each time he was soiled and wanted them to "hurry up". During treatment applications no incidents of screaming or any volatile behaviors noted.</p> <p>8/31/15 - Progress note from psychologist: The patient appears to be stable. No behaviors identified.</p>	F 329 Success Evaluation	<p><u>Success Evaluation</u></p> <p>This will be reviewed by the RN Supervisor at least weekly for twelve (12) weeks or until the facility reaches 100% success over 8 consecutive evaluations. We will then conduct bi-weekly audits until we reach 100% success at three (3) consecutive evaluations.</p> <p>Finally, we will measure practices one (1) month later. If facility is still compliant, then we conclude that we have successfully addressed the problem. These findings will be reviewed at the monthly Quality Assurance Committee meetings (QAPI).</p>		

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F 329	<p>Continued From page 20</p> <p>9/15/15 - Quarterly MDS documented the resident was alert, oriented and independent in decision making.</p> <p>9/26/15 8:30 PM Nurse's note - Resident cursing / yelling at CNA during evening care 1:1 effective.</p> <p>9/27/15 Nurse's note - ...when CNA redirected him to hallway so he could do another resident's care (name of R10) started to scream and cursed at the CNA. After dinner (name of R10) was sitting in wheel chair in front of the sink when CNA was pushing another resident's wheelchair to put to bed (name of R10) screamed at top of his lungs "this place is hell" this nurse (took name of R10) to the hallway so CNA could get through (name of R10) swang his arm and cursed at the CNA 1:1 effective after some time.</p> <p>9/30/15 9:00 PM Nurse's note - R10 yelled at alde at elevator "I don't want dinner I already ate".</p> <p>September 2015 NADS documented:</p> <p>Dementia with psychotic features: Observe for changes in behavior such as hearing voices, talking or listening to unseen person or object, running from room or unit. Report behaviors to nurse. Staff documented each shift until 9/21/15 when monitoring was discontinued;</p> <p>Resistive: Approach individual in a calm, non-threatening manner. Be consistent. Protect from injury. Give concise explanations. Document and report event to nurse. There was no documentation of whether or not the behavior occurred.</p> <p>October 2015 NADS contained no behavior</p>	F 329		

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F 329	<p>Continued From page 21 monitoring.</p> <p>10/7 - 10/14/15 - R10 was sent to the emergency room with an episode of low blood pressure and later admitted to the hospital. His discharge diagnoses included a blood infection, a urinary infection and pneumonia.</p> <p>10/14/15 - R10 returned to the facility with a physician's order for an antibiotic for 7 days.</p> <p>10/16/15 - The physician ordered a medication to increase the resident's appetite.</p> <p>10/17/15 2:00 PM Nurse's note - Resident was told that kitchen didn't have grilled cheese but sandwiches were (available). He refused yelled at staff angrily. 1:1 teaching provided not effective. Resident was assisted to leave dayroom he calmed down.</p> <p>10/18/15 2:32 PM Nurse's note - Resident noted to be cursing and yelling at CNAs during care. Shouting "get these whores away from me. They're pushing me around for no reason!". This nurse pulled resident aside for 1:1 and redirection. Resident apologized to this nurse but continued to yell and curse at the CNAs for the rest of the shift. 1:1 and redirection unsuccessful.</p> <p>10/19/15 1:05 PM Nurse's note - Resident declined lunch, upset with staff taking him to table prior to lunch time. Resident yelling and cursing at this staff calling names. After he left the table his sister was notified stated that he has been angry because he thought he will be discharged to (name of former facility he resided) when he was admitted to hospital. 1:1 teaching and explanation provided not effective noted currently calm at this</p>	F 329			

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

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FORM APPROVED
OMB NO. 0938-0391

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F 329	<p>Continued From page 22 time.</p> <p>10/21/15 - Nurses notes documented the resident was reviewed in the interdisciplinary care meeting. The note stated that the doctor was made aware of an increase in behaviors and the doctor restarted the Seroquel.</p> <p>The note did not define what behaviors were being exhibited or what interventions had been used prior to re-starting the anti-psychotic medication. No consult with the psychologist was ordered.</p> <p>10/21/15 - Physician order for Seroquel 25 mg by mouth twice a day for 3 days then increase to 25 mg three times a day for 3 days. There was no diagnosis included with this order</p> <p>10/26/15 - Physician order for Seroquel 50 mg at 8 AM , 25 mg at 2 PM and 8 PM x 3 days then 50 mg at 8 am and 2 PM and 25 mg at bedtime for dementia with psychosis.</p> <p>10/26/15 MD progress note - Behavior is increased patient becoming more angry - throwing objects on floor; verbally abusive; using bad language. Patient started on Seroquel increase gradually increase dose past 6 days no change. Plan increase slow/small dosage and observe.</p> <p>There were no nurses' notes indicating R10 was having behaviors between 10/21 and 10/26/15. There were no behavior monitoring tracking records implemented.</p> <p>Review of social service notes lacked documentation of any behavior problems.</p>	F 329		

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F 329	Continued From page 23 There was no evidence that the resident had been seen by the psychologist since 8/31/15 prior to the behaviors developing. 10/27/15 11:19 AM - interview with E14 (RN, UM) and E13 (MD) revealed that the behavior monitoring was discontinued because the resident was not having behaviors. She stated that the resident had come from another facility on Seroquel with no identified behaviors to be monitored. E14 added that she spoke to the other facility and was told he had one episode where he got argumentative. E13 added that she did not know why the resident was originally on Seroquel. E13 added that after R10 went to the hospital and returned to find out he could not return to his former facility his temperament started changing. It was confirmed that psychological consult was not ordered prior to, or with the initiation of, the Seroquel. 10/27/15 2:18 PM - Interview with E13 revealed that the Seroquel was restarted because the resident had become very distracted, angry, having tantrums and was not eating. E13 stated the medication was started for three days and increased because staff told her the behaviors were continuing. E13 was not sure what diagnosis she had documented with the medication but added that the nurse had asked her for an order for a psychological consultation today. These findings were reviewed with E2 (DON), E5 (QA Administrator) and E6 (QA Supervisor) on 10/28/15 at 2:30 PM.	F 329			
F 463	483.70(f) RESIDENT CALL SYSTEM -	F 463			

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F 463 SS=E	Continued From page 24 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 by: Based on observation, it was determined that for 5 (122, 130, 132, 207, and 209) out of 16 rooms reviewed and 1 (North 1) out of 3 shower rooms, the facility failed to ensure all portions of the call system were functioning. Findings include: 1. An observation was made on 10/20/15 at 10:35 AM of the call light cord wrapped around the grab bar in the front shower of the shower room on the North One unit, this would make it inaccessible to a resident. 2. Observations were made during Stage 1 from 10/20/15 to 10/22/15 (9:00 AM to 3:00 PM) of the survey, and on a tour on 10/23/15 from 10:30 to 11:00 AM of the call light cords in the bathrooms of the following rooms wrapped or tied around the grab bar, this would make it inaccessible to a resident. Rm 122 Rm 130 Rm 132 Rm 207 Rm 209 These findings were reviewed with E2 (DON), E5 (QA Administrator) and E6 (QA Supervisor) on	F 463 Individual Resident Impacted Identificat ion of other residents having the potential to be affected Systemic Changes	When it was brought to our attention, all five (5) rooms were checked and the call light cord was unwrapped from the grab bars. Maintenance started a room to room walk thru on all units checking bathrooms for call bell light cord wrapped around grab bars. If any were found, they were unwrapped. Maintenance and Risk Manager will check resident bathrooms and shower' bathrooms every month for correct placement of call light cords. All staff will be in serviced on the importance of maintain a working communication system for residents.	12/10/15	

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F 463	Continued From page 25 10/28/15 at 2:30 PM.	F 463 Success Evaluation	Individual responsible for Action: Risk Manager will do weekly environmental check on all units. This will occur for four (4) weeks or until 100% compliance is achieved over three (3) consecutive evaluations. Next they will conduct monthly audits until we have achieved 100% success. Finally they will conduct audits one (1) more time a month later. If 100% compliance is achieved, then we will conclude that we have successfully addressed the problem. Risk Manager will submit these findings to be reviewed at the monthly QAPI meetings.		



**DELAWARE HEALTH
AND SOCIAL SERVICES**

Division of Long Term Care
Residents Protection

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

STATE SURVEY REPORT

NAME OF FACILITY: Governor Bacon Health Center

DATE SURVEY COMPLETED: October 28, 2015

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
<p>3201</p> <p>3201.1.0</p> <p>3201.1.2</p>	<p>The State Report incorporates by reference and also cites the findings specified in the Federal Report.</p> <p>An unannounced Annual and Complaint Survey was conducted at this facility from October 20, 2015 through October 28, 2015. The deficiencies contained in this report are based on observation, interviews, and review of residents' clinical records and other facility documentation as indicated. The facility census the first day of the survey was seventy-one (71). The survey sample totaled thirty-five (35).</p> <p>Regulations for Skilled and Intermediate Care Facilities</p> <p>Scope</p> <p>Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.</p> <p>This requirement is not met as evidenced by: Cross Refer to the CMS 2567-L survey completed October 28, 2015 F226, F241, F253, F272, F278, F279, F280, F325, F329, and F463</p>	<p>Cross refer to CMS-2567-L survey ending October 28, 2015. F226, F241, F253, F272, F278, F279, F280, F325, F329, and F463</p>	

Provider's Signature Tom. Qian Title Director Date 12/2/15