

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

PRINTED: 02/15/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085051	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/14/2015
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NAME OF PROVIDER OR SUPPLIER DELAWARE VETERANS HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 100 DELAWARE VETERAN'S DRIVE MILFORD, DE 19963
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F 000	<p>INITIAL COMMENTS</p> <p>An unannounced annual survey and complaint survey was conducted at this facility from October 6, 2015 through October 14, 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 132. The survey sample totaled forty eight (48).</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; APRN-Advanced Practice Registered Nurse; 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		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 11/17/2015
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 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; COTA - Certified Occupational Therapy Assistant; OT - Occupational Therapist; cm - cubic centimeters (unit of measurement); mg (milligram) - metric unit of weight, 1mg = 0.0035 ounce; Alzheimer's Disease - degenerative disorder that attacks the brain's nerve cells resulting in loss of memory, thinking and language; 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; Broda - type of high backed wheelchair that reclines; Cancer-disease characterized by rapid growth of abnormal cells in the body; cm-centimeter, measurement of length; Dementia - severe state of cognitive impairment characterized by memory loss, poor judgement, disorientation and personality changes; Gingivitis - inflammation of gums; Hipsters-fall protection clothing product worn by individuals at risk for falls and broken bones; Incontinent - loss of control of bladder and/or bowel function; Mania - mental condition with periods of great excitement and overactivity; Meal set up - place meal and utensils on table, uncover containers, add condiments and cut up food to prepare for eating; Med - medication;	F 000		

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F 000	Continued From page 2 Mobility - move about freely; Periodontitis - inflammation of tissue around the teeth; Physical Restraints - any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body; Post-after; POA-Poper of Attorney; Propel - to move around in a wheelchair; Psychosis - loss of contact with reality; Pulse - the number of times the heart beats in one minute.	F 000			
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview it was determined that the facility failed to ensure 1 (R33) out of 43 sampled residents was free from a restraint imposed for staff convenience and not required to treat a medical symptom. Findings include: The facility's policy for Restraints revised 9/12/13 documented the following: -assess need for initiation upon admission, quarterly and any change of mental or physical status that may affect resident's personal safety	F 221	1. The Nursing Department, after further analysis, acknowledges that R33 was, in fact, restrained. This is confirmed by the fact that at the time the self-release seatbelt was applied, there was no nursing assessment completed that would determine R33's need for it. Despite the resident's daughter's consent for its use due to staff and her concerns about resident's safety, which originated from resident's previous falls from a former wheelchair, there was no medical	12/11/15	

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F 221	<p>Continued From page 3 or the safety of others; -consider least restrictive alternatives and start with the least restrictive first; -consult PT/OT (therapy); -explore alternate interventions.</p> <p>The policy included appropriate documentation for the restraint would include in the electronic medical record: -Under "Supportive Devices" - reason for restraint; type of restraint; benefits/purpose, interventions used; plan for reduction/removal; a note must also be written in the comment section if any adverse reactions are noted; -Physician's Order Sheet for Physical Restraints form; -Care plan will include customized unit of care to address type of restraint, any medical reason and interventions and the goal of the restraint use.</p> <p>Review of R33's record revealed:</p> <p>9/6/15 5:00 AM - Facility record documents R33 had an unwitnessed fall with injury from the wheelchair to the floor while sitting at the nurses station.</p> <p>9/11/15 - Therapy evaluation and treatment was started with the lowering of the back of the wheelchair and addition of an anti-trust (wedged) cushion in the wheelchair.</p> <p>9/28/15 5:05 AM - Facility record documents R33 had an unwitnessed fall from the wheelchair to the floor while sitting at the nurses station.</p> <p>9/28/15 11:56 AM - Therapy note documented the addition of leg buddy to wheelchair leg rest in order to prevent resident from getting legs behind</p>	F 221	<p>justification in place to warrant Nursing's applying seatbelt to the wheelchair or subsequent Broda chair to which the seatbelt was transferred. Additionally, despite resident's diagnoses, which include dementia with behavior disturbance, psychosis and anxiety, use of the self-release seatbelt is unwarranted because R33 is unable to purposefully release it.</p> <p>Hence, in order to ensure that R33 is free from any restraint that does not treat medical symptoms, the restraint will be removed and the daughter will be notified and provided with the explanation. Moreover, nursing staff will be re-educated regarding what constitutes a restraint and situations when it can or should be applied.</p> <p>2. To ensure that other residents, who may be affected by the cited deficient practice, are identified and free of restraint for other than a medical symptom, in addition to nursing staff re-education, an Audit, attachment (R1), will be completed to ensure that all residents with self-release seatbelt or other restraint are assessed immediately upon determination of a medical need for its use; that there is a signed consent, a complete physician order, and an identified medical diagnosis in place to better determine the need for continued restraint use.</p> <p>3. The systemic change that will be implemented to ensure that residents are free from restraint without appropriate initial assessment for its use is two-fold: All new restraint orders will be audited by</p>	

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F 221	<p>Continued From page 4 leg rests.</p> <p>9/29/15 - The facility obtained verbal consent from R33's family to use a seat belt in the wheelchair and documented this on the Physical Restraint Consent Form.</p> <p>10/2/15 - MD order for restraint wheelchair belt alarm in wheelchair for positioning and for safety. Release, check and reposition every 2 hours. There was no Physician's Order Sheet for Physical Restraints Form found in the clinical record.</p> <p>There was no information noted in the EMR in the area of "Supportive Devices".</p> <p>10/2/15 - Care plan for physical restraint need for least restrictive restraint - wheelchair belt with alarm for safety and positioning. The goal was for no complications related to use of restraint / no injury. Approaches included; review informed consent for use of restraints / assess for adverse effects of restraints, including symptoms of withdrawal / depression and reduced social contact, document reasons for ongoing use of device and why other approaches are inadequate</p> <p>10/7/15 1:06 PM - Therapy notes documented trial of resident in a Broda wheelchair with lateral(side) supports and resident to be issued the wheelchair for use after maintenance secures seatbelt.</p> <p>10/12/15 1:43 PM - Therapy documented the resident presented with safe and effective positioning in Broda chair with lateral supports.</p>	F 221	<p>facility QA using the audit tool (R1) and all existing restraints will be monitored as necessary and quarterly thereafter by the IDCC Team, which will include nursing collaboration with the therapy department to address the continuance of the restraint and post-fall interventions that may require additional support.</p> <p>4. The corrective actions will be monitored through weekly review of restraints during the weekly QA IR meeting, and any deficiencies will be addressed by nursing administration to ensure staff accountability, which will include disciplinary action. The audits will continue until 100% compliance is reached.</p>	

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F 221	Continued From page 5 10/13, 10/14, 10/15/15 - R33 was observed to be in a Broda wheelchair with a seatbelt. 10/14/15 about 12:00 PM interview with E22, (OT) and E23, (COTA) revealed that the therapy department did not issue a seatbelt to this resident and that therapy had not assessed R33 for the use of a seat belt restraint. It was revealed that nursing initiated the seat belt and the therapy department only had it transferred from the original wheelchair when the new wheelchair was issued. E22 stated that as a therapist she does not use seat belts unless all other seating and positioning interventions have failed. 10/14/15 12:30 PM - Interview with E15, (RN, UM) revealed that she could not find a restraint assessment for R33 and she stated the seat belt was added after the resident had falls from the wheelchair. E15 stated that she was not working that day and another unit manager had obtained the order for the seat belt. E15 spoke with the other unit manager who confirmed an assessment for the use of the restraint was never conducted. The facility initiated the use of a wheelchair seat belt in the absence of a comprehensive assessment for its use, in the absence of a medical symptom, without therapy consultation and in the appearance of staff convenience to prevent the resident from getting out of the wheelchair unattended.	F 221			
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY These findings were reviewed with E1, NHA and E2, acting DON on 10/14/15 at 3:30 PM.	F 241		12/11/15	

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F 241	<p>Continued From page 6</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by :</p> <p>Based on dining observations and interview it was determined that the facility failed to promote care for residents in a manner that enhanced each resident's dignity and respect in full recognition of his/her individuality for 5 (R108, R 92, R18, R36 and R21) out of 48 sampled residents. Time frame from when the first and last resident was served and began to eat ranged from 23 to 27 minutes, resulting in residents watching other residents eat before receiving their meal.</p> <p>1. 10/8/15 lunch observation on GOLD unit's dining/activity room - meal cart arrived at 12:00 PM and sixteen (16) residents dined for lunch with R108, R92, R18 and R36 seated at the same table. *12:05 PM R108 was served and was being fed by E18 (CNA). *12:14 PM R92 meal was set up and the resident started with self-feeding. *12:18 PM R18 was served and was being fed by E19 (CNA). *12:28 PM R36 was starting to be fed by E18 after the CNA finished feeding R108.</p> <p>It was not clear why E18, who sat between R108 and R36, could not assist both residents with their meal at the same time to avoid the 23 minute delay for R36.</p>	F 241	<p>We cannot go back and enhance the dining experience for any of the residents addressed in this citation</p> <p>2. All residents dining on the Gold Unit are at risk to not be treated with dignity and respect at meal time by our current deficient practice.</p> <p>3. To ensure staff is maximized during the resident meal times, breaks and lunch times have been revised for all members of the nursing staff on the Gold Unit so that none will be taken during the residents' meal times. Implementation of a new procedure required that no more than 5 residents will be seated at one table of which only 2 residents may require physical assistance for eating (unless there is more than 1 staff member at the table). Residents requiring physical assistance will be seated next to each other to allow one staff member to assist both with feeding. The other residents at the table will be independent or require only cueing. The level of assistance required by a resident will be noted on their meal ticket. Once seated, the meals will be served to everyone at that table beginning with</p>		

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F 241	<p>Continued From page 7</p> <p>2. 10/12/15 lunch observation on GOLD unit's dining/activity room - meal cart arrived at 11:58 AM and fifteen (15) residents dined for lunch with R92, R18, R21 and R108 seated at the same table. Two CNAs were initially assisting with meal service.</p> <p>*12:03 PM R92 was set up by E20 (CNA) who proceeded to self-feed. *12:06 PM E20 served a tray at another table. *12:08 PM a third CNA returned from her meal break and assisted by setting up R18's (required physical assistance for eating) meal. The resident picked up a french fry, looked at it then placed it back on the plate. R18 watched around the room and did not touch her food. *12:17 PM a fourth CNA returned from her meal break and began to assist with the meal service. *12:18 PM two CNAs simultaneously served and set up R21 and R108. R21 began to self-feed, 15 minutes after his tablemate began eating. *12:22 PM R18 was assisted to be fed 14 minutes after the meal was set up. *12:30 PM R108 was started to be fed his meal, 27 minutes after a tablemate began eating.</p> <p>These findings were reviewed with E1 (NHA) and E2 (acting DON) on 10/14/15 at 3:30 PM.</p> <p>F 250 SS=D 483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p>	F 241	<p>independent, cueing, and lastly physical assist so that the staff member can immediately begin to assist the dependent residents. Any additional residents brought in on to the dining room will be seated at another table and the process will be repeated.</p> <p>Mandatory hour long training sessions were provided by the staff education department on 12/2/15, 12/3/15, 12/4/15, 12/9/15 and 12/10/15 (multiple sessions offered daily). The dining procedure as outlined above was included in this training. Additionally, the training addressed the resident dignity issue of meals being left on trays.</p> <p>4. An audit tool (Attachment 241A) has been developed that monitors meal arrival times and adequate staff assistance. The unit manager/designee will conduct random audit at least 3 times per week until 100% compliance is reached. The results of the audits will be reported to the monthly nursing QA committee. Resulting expectation is that 100% compliance is reached within 3 months; if not achieved within that time frame additional training and disciplinary actions will ensue.</p>	12/11/15

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F 250	<p>Continued From page 8</p> <p>This REQUIREMENT is not met as evidenced by :</p> <p>Based on observation, record review and interview it was determined that for 1 (R149) out of 48 sampled residents the facility failed to provide medically-related social services to determine the resident's need for dental consultation. Findings include:</p> <p>Review of R149's record revealed: 9/22/15 - R149 was admitted to the facility.</p> <p>9/28/15 - Admission MDS assessment documented the resident had obvious or likely cavity or broken natural teeth. The care area assessment triggered for dental status and the facility indicated they would proceed with a care plan.</p> <p>10/1/15 - Care plan for alteration in dental status with poor dentition related to broken / decayed teeth / poor oral hygiene / history of periodontitis. In the area of evaluation of the care plan staff documented that the resident would be offered the opportunity to see a dentist for evaluation and cleaning if he allows.</p> <p>10/1/15 - Social service note with a summary of care planning meeting on this date documented that the resident's nephew attended. There was no mention of dental care being discussed.</p> <p>10/6/15 3:04 PM - The resident was observed to have missing / broken teeth.</p> <p>10/8/15 10:39 AM - An interview with E24 (RN / nursing supervisor) and E25 (LPN) revealed that there was no specific assessment form used to</p>	F 250	<ol style="list-style-type: none"> 1. R142 was seen by a dental provider on 10/28/15 for cleaning and exam. Resident declined restoration services offered. Resident has a follow up appointment for 12/4/15. (Attachment) 2. All residents have a potential to be affected if the facility fails to provide medically- related social services. New admission MDS Section L records for the past 6 month period will be reviewed. Any dental issues identified will be addressed upon finding. (Attachment) 3. The measures that will be put in place to ensure that the deficient practices do not reoccur are: <ol style="list-style-type: none"> a. The admissions coordinator will complete the preadmission assessment and nursing/medical notification form which includes dental issues identified by provider, family, resident, or screening. (Attachment &) b. Dental issues will be added to the quarterly assessment care plan meeting topics and noted by social service staff in the resident record. 4. The admissions nurse will monitor dental issues identified during the admissions process to ensure a medical explanation of action to be taken was initiated within 14 days of admission. (Attachment) The social worker will audit resident charts in which dental 	

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F 250	<p>Continued From page 9</p> <p>ask residents if they wanted dental care and that staff just know to ask the residents. E24 then went down to the resident's room to ask him if he wanted to see a dentist. E24 also put a phone call into the resident's responsible party to see if they wanted a dental consultation. The resident denied needing to see a dentist.</p> <p>10/8/15 - Nurse's note documented that the family would like the resident to see a dentist.</p> <p>10/9/15 2:00 PM - E8, (RNAC) revealed that she was not the RNAC for that unit at the time of the 10/1/15 care conference but it was noted a family member did attend and she confirmed that there was no mention of dental services being discussed. When asked how it would be determined if a resident / family member wanted a dental consult she responded that she would hope it would be discussed at the care conference.</p> <p>These findings were reviewed with E1 (NHA) and E2 (acting DON) on 10/14/15 at 3:30 PM.</p> <p>F 252 SS=E 483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT</p> <p>The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation it was determined that the facility failed to provide a homelike environment by serving meals to 13 (R25, R33, R36, R43, R44</p>	F 250	<p>issues were identified in the care plan meeting to ensure the concern has been addressed. Social Worker and Admission Coordinator will report findings at the Quarterly Quality Assurance meeting.</p> <p>1. Email directive was sent to all staff: For residents eating on the units, contents on the tray are to be removed from the</p>	12/11/15

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F 252	Continued From page 10 , R60, R61, R71, R80, R102, R133, R143, and R146) out of 48 sampled residents on trays in lounge areas used as dining rooms on 3 out of 4 units. Findings include: * 10/6/15 at 9:00 AM - 6 (R25, R33, R43, R44, R80, and R102) out of 6 residents dining in the red unit ate their meal on trays. * 10/6/15 at 9:10 AM - 1 (R71) out of 1 resident dining on the blue unit ate his meal on a tray. * 10/8/15 at 12:28 PM - 1 (R36) out of 16 residents on the gold unit was fed lunch from a tray. * 10/8/15 at 12:29 PM - 1 (R71) out of 2 residents dining on the blue unit ate his meal on a tray. * 10/9/15 from 8:12 to 8:20 AM - 8 (R25, R33, R43, R44, R60, R102, R133 and R143) out of 8 residents dining on the red unit ate their meal on trays. * 10/9/15 from 8:25 to 8:45 AM - 1 (R71) out of 1 resident dining on the blue unit ate his meal on a tray. * 10/9/15 from 11:55 AM to 12:30 PM - 3 (R61, R71 and R146) out of 4 residents dining on the blue unit ate their meals on trays. * 10/12/15 from 12:05 to 12:22 PM - 2 (R71 and R146) out of 2 residents dining on the blue unit ate their meals on trays. Findings from the red and blue units were reviewed with E2 (Acting DON) on 10/14/15 at 11:10 AM. Findings were reviewed with E1 (NHA) and E2 on 10/14/15 at 3:30 PM.	F 252	tray and placed on table in front of resident as done in the dining room. (Attachment) 2. All Resident are at risk for having the potential to be affected by deficient practice of not providing a home like environment by removing the contents from a food tray to the table. 3. The practice of removing food from tray when serving a resident meal on the unit will be added to the new employee orientation and reinforced daily on the unit . POC training to all nursing staff will reinforce the homelike environment concept of why the contents should be removed from trays. 4. Unit manager will conduct audits weekly and report to Nursing Quality Assurance Committee until compliance is reached for two consecutive months.		
F 253	483.15(h)(2) HOUSEKEEPING &	F 253		12/11/15	

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F 253 SS=B	<p>Continued From page 11 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 :</p> <p>Based on observation and interview it was determined that the facility failed to maintain housekeeping and maintenance services for 7 (1060, 1207, 1210, 1211, 1274, 1275, 1277) out of 15 rooms reviewed in the facility. Findings include :</p> <p>Observations during the initial tour on 10/6/15 and the environmental tour on 10/12/15 between 10:00 AM - 11:00 AM revealed</p> <ul style="list-style-type: none"> -Room 1060-2 scuff marks on lower right wall below chair rail -Room 1207-1 fall mats with frayed corners, limited the ability to clean, dried tan spot around 3 inches in diameter on one mat, white discoloration widespread over majority of the mats, upper side rail by window with numerous brown and tan spots -Room 1210-1 lower section of small wall with drywall damage -Room 1211-1 outside of bathroom door with horizontal scrape near bottom; paint on headboard; brown stains on side rail -Room 1274-1 black stains on floor near toilet -Room 1275-2 dirty floor in sleeping/living area; bathroom floor and vanity dirty -Room 1277-2 marks on bottom of closet door several vertical scratches/damage to wall at head of bed 	F 253	<ol style="list-style-type: none"> 1. Immediate repair/cleaning of areas identified in rooms 1060, 1207, 1210, 1211, 1274, 1275, 1277 was completed on 10/14/15 upon notification by surveyor. 2. All residents have the potential of being affected by deficiencies in maintenance and housekeeping services. A sweep was completed of each resident room to identify areas in need of repair/cleaning. Work orders were completed and housekeeping staff received assignments based on findings. 3. The measures that will be put in place to ensure that the deficient practices do not recur are: <ol style="list-style-type: none"> a. Hired a new housekeeping supervisor who is responsible for completing rounds daily and completing training on proper cleaning techniques and identification of areas requiring attention. b. Educate housekeeping and nursing on identifying and reporting maintenance items through our computer work order maintenance system for repair. c. Increase maintenance room rounds from monthly to weekly to identify and repair damage in resident rooms. 	

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F 253	Continued From page 12 These findings were reviewed with E16 (Maintenance Supervisor) on 10/14/15 at 8:30 AM and with E1 (NHA) and E2 (acting DON) on 10/14 /15 at 3:30 PM.	F 253	4. The housekeeping supervisor and maintenance superintendent will monitor the work of staff. Upon completion of work order or housekeeping assignment, the supervisor will inspect the repair/work to ensure completion and work meets standards. Chief of Operations will conduct a facility wide tour monthly to observe environmental compliance and will report number of findings to Quality Assurance Committee quarterly.		
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 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;	F 272		12/11/15	

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F 272	<p>Continued From page 13</p> <p>Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>This REQUIREMENT is not met as evidenced by :</p> <p>Based on record review it was determined that for 1 (R120) out of 48 sampled residents the facility failed to ensure accuracy of the MDS in the area of dental services. Findings include:</p> <p>Cross refer F411.</p> <p>The following was recorded in R120's clinical record:</p> <p>10/28/14 - R120 was admitted to the facility.</p> <p>10/28/14 - Medical note that resident has many missing teeth and gingivitis.</p> <p>11/10/14 - Admission MDS indicated the resident had no dental problems.</p> <p>The facility failed to correctly document R120's dental issues on the comprehensive assessment.</p> <p>Findings were reviewed with E1 (NHA) and E2 (</p>	F 272	<ol style="list-style-type: none"> 1. R120's corrected comprehensive MDS assessment Section L (Attachment 272A) has been corrected and submitted by facility RNAC. It now reflects his current dental status. 2. All residents have the potential to have information documented incorrectly on a comprehensive MDS assessment, whether the incorrect entry results from a human data input error, an oversight, or an incorrect assessment. All admission records (medical and nursing notes to determine dental concerns) from the past 6 months will be reviewed for accuracy and if found to be inaccurate, a correction will be submitted by the RNAC. (Attachment 272B) 3. To prevent this from recurring, upon admission to DVH, the Admission Coordinator will determine with the Resident/Responsible Party if there are any dental concerns. This information will 		

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F 272	Continued From page 14 acting DON) on 10/14/15 at 3:30 PM.	F 272	be noted on the DVH PRE-ADMISSION SCREENING ASSESSMENT (Attachments 272 C 1-3) along with other important information for this new resident . This written communication will be provided to the Medical Team, Unit Manager, and RNAC. As part of the Admission History and Physical, the physician will perform an oral exam and document any obvious dental concerns. When completing the resident's admission comprehensive MDS assessment, the RNAC will review both the Admission Coordinator's communication and the Physician's admission note and complete Section L based on this information 4. The QA nurse will review/ audit Section L of the MDS on all new admissions. (Attachment 272D). The QA nurse will review the admission nurse's communication and the admission physician's note in comparison with information reflected on the MDS assessment to ensure accuracy. After 2 months of compliance, the QA will perform random audits on at least 2 new admissions (if applicable) per month and report at the Monthly Nursing QA.		
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	F 279		12/11/15	

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F 279	<p>Continued From page 15</p> <p>objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>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).</p> <p>This REQUIREMENT is not met as evidenced by :</p> <p>Based on record review and interview it was determined that for 1 (R33) out of 48 sampled residents the facility failed to develop a comprehensive care plan with clear approaches and measurable goals for identified needs. Findings include:</p> <p>Review of R33's record revealed:</p> <p>1a. 10/15/14 - R33's care plan for falls, high risk for injury from fall due to poor safety awareness and non compliance with safe transfers and attempts to get out of bed without assist. The goal was minimal injury from falls. Approaches included: bed alarm when in bed for safety, low bed fall mats when in bed for safety, do not leave unattended, 2 or more assist with mechanical lift transfers, every one hour checks, observe for increased restlessness and anxiety inform nursing (5/19/15), clip alarm in bed at all times (6/12/15), clip alarm in chair at all times (6/16/15).</p>	F 279	<p>1A. A IDCC team meeting was held to discuss R33's fall care plan. The care plan was updated to reflect clear, current approaches and measurable goals. The primary intervention to address resident's restlessness is to spend 1:1 time in her room. If her restlessness doesn't decrease, nursing judgement will determine the appropriate course of action to calm resident and ensure safety. Other approaches include managing resident's pain and continuing use of safety devices and equipment.</p> <p>2A. All residents are at risk of not having care plans updated to reflect their current status. An audit (Attachment 279B) of all fall care plans was completed to ensure that the care plans have clear approaches and measurable goals. Care plans in need of revision were identified and revisions are ongoing.</p>	

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F 279	<p>Continued From page 16</p> <p>The facility failed to have a measurable goal for R 33's fall care plan.</p> <p>b. The facility's policy for Restraints revised 9/12/13 documented the following: -Care plan will include customized unit of care to address type of restraint, any medical reason and interventions and the goal of the restraint use.</p> <p>10/2/15 - R33 had a MD order for restraint wheelchair belt alarm in wheelchair for positioning and for safety. Release, check and reposition every 2 hours.</p> <p>10/2/15 - Care plan for physical restraint need for least restrictive restraint - wheelchair belt with alarm for safety and positioning. The goal was for no complications related to use of restraint / no injury. Approaches included; review informed consent for use of restraints / assess for adverse effects of restraints, including symptoms of withdrawal / depression and reduced social contact, document reasons for ongoing use of device and why other approaches are inadequate</p> <p>R33's comprehensive care plan for restraint use lacked the medical reason, clear instructions for its use and a measurable goal for the use of a restraint.</p> <p>10/14/15 8:41 AM - Interview with E14 (RN) revealed that the facility was aware that they had issues in the area of care planning and were starting a performance improvement plan to address them.</p> <p>These findings were reviewed with E1, (NHA) and</p>	F 279	<p>3A. The DON met with nursing leadership staff to educate on the care planning process which included a systemic review. The DON will continue care planning education to include implementation of resident centered care plan reflecting clear approaches and measurable goals. After a fall occurs, the RNAC/Unit Manager will review/revise resident's fall care plan to ensure the fall care plan includes clear, current interventions and appropriate measurable goals.</p> <p>4A. RNACS will begin attending weekly QA IR meetings during which all falls are reviewed. During the weekly QA IR meeting, the fall care plan will be reviewed to ensure it was updated to reflect the most current interventions and contains a measurable goal. Any deficiencies will be addressed by nursing administration to include staff training and ensure accountability through progressive discipline. These reviews will continue until 100% compliance is reached.</p> <p>1B. R33's restraint care plan was updated to reflect the medical reason for restraint use and measurable goals.</p> <p>2B. All residents are at risk of not having care plans updated to reflect their current status. An audit (Attachment 279B) of all restraint care plans was completed to ensure the care plan included the medical reason for the restraint, clear instruction for use and measurable goals for restraint use. Care plans in need of revision were identified and revisions are ongoing.</p> <p>3B. The DON met with nursing leadership staff to educate on the care planning process which included a systemic review.</p>	

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F 279	Continued From page 17 E2, (acting DON) on 10/14/15 at 3:30 PM.	F 279	The DON will continue care planning education to include implementation of resident centered restraint care plan including medical reason, clear instructions for use and measurable goals 4B. RNACS will begin attending weekly QA IR meetings during which all restraints are reviewed. During the weekly QA IR meeting, the restraint care plan will be reviewed to ensure it was updated to reflect the medical reason for the restraint, clear instruction for use and measurable goals. Any deficiencies will be addressed by nursing administration to include staff training and ensure accountability through progressive discipline. These reviews will continue until 100% compliance is reached.		
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. 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	F 280		12/11/15	

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F 280	<p>Continued From page 18 and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview it was determined that the facility failed to revise the care plan to reflect the resident's current status and/or interventions for 3 (R33, R52 and R55) out of 48 sampled residents. For R33 the care plan was not updated for a fall with new post fall interventions. For R52 the care plan was not updated for refusal of dental services. For R55 the care plan problem for safety hazards did not include several behaviors and an implemented intervention.</p> <p>1. The following was included in review of R33's clinical record:</p> <p>10/15/14 - R33's care plan for falls, high risk for injury from fall due to poor safety awareness and non compliance with safe transfers and attempts to get out of bed without assist. The goal was minimal injury from falls. Approaches included; bed alarm when in bed for safety, low bed fall mats when in bed for safety, do not leave unattended, 2 or more assist with mechanical lift transfers, every one hour checks, observe for increased restlessness and anxiety inform nursing (5/19/15), clip alarm in bed at all times (6/12/15), clip alarm in chair at all times (6/16/15).</p> <p>1/25, 5/18, 5/23, 6/10, 6/11, 8/29, 9/28, 10/2/15 - R33's care plan included an evaluation of falls on each of these dates.</p>	F 280	<p>1A. A IDCC team meeting was held to discuss R33's fall care plan. The care plan was updated to reflect clear, current approaches and measurable goals specific to resident's most recent falls. Those post-fall interventions included wheelchair positioning, medication adjustments, and continuance of safety measures already in place to address resident's restless at night, which were determined to be a contributing factor to the resident's fall. The goal remains to prevent future falls and ensure resident's safety. Other approaches include managing resident's pain and continuing use of safety devices and equipment.</p> <p>2A. All residents are at risk of not having care plans updated to reflect their current status. An audit (Attachment 280D) of all fall care plans was completed to ensure that the care plans have clear approaches and measurable goals. Care plans in need of revision were identified and revisions are ongoing.</p> <p>3A. The DON met with nursing leadership staff to educate on the care planning process which included a systemic review. The DON will continue care planning education to include implementation of resident centered care plan reflecting clear approaches and measurable goals.</p>	

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F 280	<p>Continued From page 19</p> <p>9/6/15 5:00 AM - A facility incident report documented a fall from the wheelchair with injury. This fall was not mentioned in the care plan evaluation. Post 9/6/15 fall interventions noted in the facility investigation included; clip alarm to wheelchair, therapy evaluation for wheelchair positioning, medication changes, hipsters and review of medication times. These approaches were not added to the care plan.</p> <p>10/14/15 8:41 AM - Interview with E14 (RN) revealed that the facility was aware that they had issues in the area of care planning and were starting a performance improvement plan to address them.</p> <p>2. The following was included in review of R52's clinical record:</p> <p>1/30/15 - Care plan for dental status related to broken/decayed teeth, poor oral hygiene gingivitis and dental caries with an intervention of dental referral if resident will allow.</p> <p>9/22/15 10:37 AM - Nurse's note resident had all of his teeth rotting. Most likely painful when teeth are brushed. Resident refuses to have teeth pulled.</p> <p>9/24/15 - Significant change in status MDS documented that the resident had obvious or likely cavity or broken natural teeth.</p> <p>10/13/15 2:36 PM - Interview with E25 (LPN) revealed that dental services have been attempted through his guardian and the resident did not want dental services. An appointment was made at one time and he refused to go. The</p>	F 280	<p>After a fall occurs, the RNAC/Unit Manager will review/revise resident's fall care plan to ensure the fall care plan includes clear, current interventions and appropriate measurable goals. Systemic change has been initiated to ensure the RNAC is actively involved in coordinating the IDCC process. Prior to the care plan meeting the RNAC will review resident care plans for accuracy and further updates, if necessary, will be made during the meeting.</p> <p>4A. RNACS will begin attending weekly QA IR meetings during which all falls are reviewed. During the weekly QA IR meeting, the fall care plan will be reviewed to ensure it was updated to reflect the most current interventions and contains a measurable goal. Any deficiencies will be addressed by nursing administration to include staff training and ensure accountability through progressive discipline. These reviews will continue until 100% compliance is reached.</p> <p>1B. A IDCC team meeting was held to discuss R52's dental care plan. The care plan was updated to reflect resident's refusal of dental services and diet modifications, as requested, to meet his needs. The care plan approaches were updated to include assessing for oral pain, offering quarterly referrals for dental services, educating resident regarding oral status and plan of care, offering diet modification, and encouraging oral hygiene.</p> <p>2B. All residents are at risk of not having care plans updated to reflect their current status. An audit (Attachment 280D) of all</p>	

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F 280	<p>Continued From page 20</p> <p>resident ate a modified diet as a result of his unmet dental needs. E25 confirmed that this information was not in the care plan. E25 further revealed that the RNACs develop and do all updates to the care plans not the nurses on the unit.</p> <p>R52's care plan did not describe the resident's refusal of dental services, dietary modifications at the request of the resident to deal with these dental issues and any approaches to encourage compliance with needed dental care.</p> <p>Cross Refer F319 and F329.</p> <p>3. Review of R55's record revealed: 6/9/15 R55's care plan problem for safety hazards to self; non-compliant with care plan; potential for disruptive behavior verbally or physically; pacing/rummaging; elimination in inappropriate places. Manifested by yelling/ disruptive sounds; pacing/rummaging; elimination (urinating) in inappropriate places; forgets to use walker with ambulation; when in wheelchair stands without assist or walker. Nurse interventions included: administer medications as ordered, assess for effectiveness and side effects, notify MD/APRN of increased behaviors, 1:1/talking, activity, assess/treat pain, offer food/ fluids, time to calm, reapproach, music, phone call to family, reassure, redirect, toilet/offer toilet. CNA interventions included record behaviors, maintain safety of residents and others, offer foods or fluids, report pain indicators, toilet, activity, reassure, change position, take for walk, offer conversation, offer music/video/tape, time to calm and reproach, phone call to family, redirect restlessness into productive activity, notify nurse of increased behaviors.</p>	F 280	<p>oral/dental care plans was completed to ensure that the care plans reflect residents' current status and interventions are current and appropriate. Care plans in need of revision were identified and revisions are ongoing.</p> <p>3B. The DON met with nursing leadership staff to educate on the care planning process which included a systemic review. The DON will continue care planning education to include implementation of resident centered care plan reflecting clear approaches and measurable goals with regard to the resident's dental needs. After becoming aware of dental concerns, the RNAC/Unit Manager will review/revise resident's dental care plan to ensure it includes reflects resident's current dental status and has clear approaches. Systemic change has been initiated to ensure the RNAC is actively involved in coordinating the IDCC process. Prior to the care plan meeting the RNAC will review resident care plans for accuracy and further updates, if necessary, will be made during the meeting.</p> <p>4B. A member of nursing administration will be assigned to audit the dental care plan of all residents in which a dental concern was addressed to ensure it was updated to reflect resident's current status and clear approaches. The audit will be reviewed at the monthly nursing QA meetings. Any deficiencies will be addressed by nursing administration to include staff training and ensure accountability through progressive discipline. These audits will continue until</p>	

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F 280	<p>Continued From page 21</p> <p>10/13/15 interview at 10:36 AM E7 (UM) stated a fabric STOP sign (attached by Velcro) was placed at night across doorways of residents that R55 would bother. The UM confirmed this intervention was not included in the care plan and stated that it could be added.</p> <p>10/14/15 interview at 11:00 AM with E8 (RNAC) was informed about R55's behaviors of entering sleeping residents' rooms, unhooking alarms, placing fall mats on top of sleeping residents and inappropriate touching of female chests and confirmed they were not included in the care plan.</p> <p>The resident's care plan about safety hazards was not updated to include an intervention being used or additional behaviors R55 exhibited.</p> <p>These findings were reviewed with E1 (NHA) and E2 (acting DON) on 10/14/15 at 3:30 PM.</p>	F 280	<p>100% compliance is reached.</p> <p>1C. A IDCC team meeting was held to discuss R55's behavior care plan. The care plan was updated to reflect resident's current behaviors and interventions. Behaviors exhibited by resident that were added to the care plan include wandering into other resident's rooms, unhooking alarms, placing fall mats on top of sleeping residents, unhooking alarms, and inappropriately touching females' chests. Additionally, the care plan was updated to include the safety intervention of utilizing a Velcro stop sign to discourage wandering behavior.</p> <p>2C. All residents are at risk of not having care plans updated to reflect their current behaviors and interventions. An audit (Attachment 280D) of all behavior care plans was completed to ensure that the care plans reflect residents' current behaviors and interventions. Care plans in need of revision were identified and revisions are ongoing.</p> <p>3C. The DON met with nursing leadership staff to educate on the care planning process which included a systemic review. The DON will continue care planning education to include implementation of resident centered care plan reflecting clear approaches and measurable goals with regard to the resident's behaviors. After becoming aware of behaviors, the RNAC/Unit Manager will review/revise resident's behavior care plan to ensure it includes reflects resident's current behaviors and safety interventions. Systemic change has been initiated to ensure the RNAC is actively involved in</p>	

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F 280	Continued From page 22	F 280	coordinating the IDCC process. Prior to the care plan meeting the RNAC will review resident care plans for accuracy and further updates, if necessary, will be made during the meeting. 4C. A member of nursing administration will be assigned to audit the behavior care plan of all residents in which behaviors were addressed to ensure the care plan updated to reflect resident's current behaviors and interventions. The audit will be reviewed at the monthly nursing QA meetings. Any deficiencies will be addressed by nursing administration to include staff training and ensure accountability through progressive discipline. These reviews will continue until 100% compliance is reached.	
F 319 SS=E	<p>483.25(f)(1) TX/SVC FOR MENTAL/ PSYCHOSOCIAL DIFFICULTIES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, observation and interview it was determined that the facility failed to provide treatment and services to correct mental or psychosocial adjustment difficulty for 1 (R55) out of 48 residents. Findings include:</p> <p>Review of R55's record revealed:</p>	F 319	<p>1. We cannot go back and make any changes to R55's documentation that was reviewed during the survey.</p> <p>2. All residents with a psychosocial care plan have the potential of not having the interventions listed in their care plan evaluated for effectiveness. The social</p>	12/11/15

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F 319	<p>Continued From page 23</p> <p>5/15/15 - Admission with diagnosis of dementia.</p> <p>5/15/15 - Care plan problem of psychosocial adjustment related to loss of independence and change in lifestyle for behaviors including looking for his wife and asking about going home. Interventions included providing reassurance, offering conversation on subjects of interest to the resident, inviting to attend activities of the day. Social services to encourage the resident to express feelings to allow him to avoid feelings of anxiousness and depression or missing his wife and home with her [This is the only approach for social services documented in the resident's care plan]. Activities to identify interests and strengths that can help redirect and engage the resident. This problem's goal is to participate in activities, perform ADLs, interact appropriately and communicate needs.</p> <p>5/19/15 - Care plan evaluation of psychosocial problem included the resident was moved to the gold neighborhood (locked unit) on 5/18/15 after an incident that resulted in an elopement. The resident did become confused at times and forgot where he is and staff should continue to offer conversation and redirect his attention.</p> <p>5/25/15 - Care plan problem for activities (revised 7/11/15) included resident interests, being a medic in the army, birthplace, church involvement, love of dogs, desire to dress nice, going to CHEER, singing, baking. Approaches included "I am usually flying around in my wheelchair, be careful of me I might run over you. I do not stay in one place for long. It's hard to keep my attention. Invite to activities such as music, entertainment, physical games outside, singing, pet visits."</p>	F 319	<p>services department will review all current psychosocial care plans to ensure interventions are appropriate and evaluations are completed.</p> <p>3. The social services department will provide 1:1 visits for all newly admitted residents at least monthly for the first three months to determine the resident's level of adjustment to the facility. The social worker will document each visit in the social service progress notes and make adjustments to the psychosocial care plan as needed. At the first quarterly review, the social worker will evaluate the effectiveness of the interventions and goal (s) of the psychosocial care plan and update as needed.</p> <p>4. The Chief of Operations/designee will audit psychosocial care plans on a monthly basis to ensure evaluation of the interventions were completed and report the findings to the quarterly QA committee until compliance is reached for 3 consecutive months.</p> <p>319 (Behaviors and Medication)</p> <p>Part II (see F329)</p> <p>1. We cannot go back and make any changes to R55s past medication management. An assessment of resident's behaviors was completed by the medical team and adjustments were made to the medication regimen. APN will review behavior documentation and medication effectiveness biweekly.</p>		

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F 319	<p>Continued From page 24</p> <p>6/9/15 - Care plan included the problem of safety hazard to self with potential for disruptive behavior (verbally and physically), pacing/ rummaging and elimination in inappropriate places related to dementia. Behaviors included yelling/disruptive sounds and pacing/rummaging. Nurse interventions: give medications as ordered, assess for effectiveness and adverse effects. Notify MD/NP of increased behaviors.... reapproach, music, phone call to family, redirect CNA interventions: record behaviors, maintain safety of residents and others.....redirect restlessness into productive activity, notify nurse of increased behaviors.</p> <p>There had been no revisions to the behaviors or approaches. While the care plan was revised on 6/9/15 it is unclear how the facility the evaluated the effectiveness of interventions in the presence of ongoing behaviors.</p> <p>6/30/15 (5:33 PM) nurses' note - E10 (Physician) was contacted regarding mania and agitation and physical behavior directed toward others including running into other residents with his wheelchair and putting hands on other residents. Ativan 0.5 mg to be given every 6 hours PRN ordered.</p> <p>Review of 6/29/15 through 10/11/15 nurses' notes :</p> <p>R55 propelled himself in a wheelchair (often very fast) up and down the hallways on the locked unit where he resided almost on a daily basis. R55 would run into other residents (almost running over their feet, actually hitting their feet/ankles), walls, tables, med carts and staff with his wheelchair. Additional resident behaviors (number of occurrences listed) discovered in the</p>	F 319	<p>Findings will be discussed with medical director and communicated to nursing administration. Further adjustments to resident's psychotropic medication to be approved by the medical director and resident's psychiatrist will be consulted.</p> <p>2. All residents run the risk of exhibiting periods of increased anxiety and behaviors which may necessitate the initiation/continued use of psychotropic medication. When such a resident is identified the nurse will notify the APN or medical director who will assess resident and consult with the resident's psychiatrist. Once measures to lessen the degree of anxiety and decrease the frequency of the behaviors are determined the plan of care will be implemented and communicated to nursing staff via IDCC and/or a physician order. Nursing will communicate any behavioral concerns to the medical team.</p> <p>3. When a resident behavior is identified, nursing will initiate a 24 hour behavior worksheet for the purpose of monitoring the behavior. Mandatory hour long training sessions were provided by the staff education department on 12/2/15, 12/3/15 , 12/4/15, 12/9/15 and 12/10/15 (multiple sessions offered daily) on completing the worksheet (Attachment 329B). The unit manager will review the behavior worksheets daily and discuss the behaviors and interventions with the IDT. The care plan will be updated by the RNAC to reflect resident's current behaviors and appropriate interventions. The unit manager, RNAC and medical team will meet weekly to review resident's</p>		

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F 319	<p>Continued From page 25</p> <p>nurses notes included:</p> <ul style="list-style-type: none"> *entered rooms of sleeping residents - 20 times (ransacked room, took clothing, removed bed linens, changed TV channels) *touched other residents inappropriately - 7 *grabbed/pulled/pushed other residents - 6 *removed other residents' alarm - 2 *placed fall mats from floor on top of sleeping resident - 2 *unplugged bed and pulled call light from wall of sleeping resident - 1 *physically abusive to staff - 4 <p>7/9/15 (9:30 PM) PRN Ativan 0.5 mg - 11:08 PM "improved but still present" [manic zooming up and down hallway]. Nurses' note documented the resident taken for a walk and afterward had no behaviors.</p> <p>7/10/15 - E9 (NP) documented the resident's anxiety, striking fellow residents with wheelchair, unable to be redirected and PRN Ativan used on a regular basis. Psychiatry recommended routine Ativan 0.5 mg twice a day and 0.5 mg every 6 hours PRN. E10 (Medical Physician) ordered routine Ativan 0.5 mg twice daily and ordered 0.25 mg (half the strength) of PRN Ativan every 8 hours [less often than recommended by psychiatry] for manic behavior, agitation, restlessness or distress-related reactions. Rationale written for the lower dose was due to side effects of drowsiness and dizziness that increased the risk for falls which could be dangerous given that the resident was on a blood thinner.</p> <p>7/10/15 - MAR revealed behavior monitoring every shift for being more restless than normal, exit seeking, pushing / grabbing staff and other</p>	F 319	<p>s behavior and determine an individualized current plan of care.</p> <p>4. The behavior worksheets will be audited at the monthly nursing QA meeting for a period of three months to ensure that resident behaviors are communicated between the medical and nursing departments. Interventions will be reviewed for effectiveness and any discrepancies will be addressed through education and progressive discipline.</p>	

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F 319	<p>Continued From page 26</p> <p>residents, pacing / rummaging and self-ambulating in wheelchair without regard for safety of self or others. The MAR contained initials of the documenting nurse, however the number of episodes of behaviors were not recorded when the document was printed for the surveyor by the facility.</p> <p>7/15/15 (11:58 AM) nurses' note - bruise right eye</p> <p>7/15/15 (10:06 PM) nurses' note documented R 55 was given his scheduled dose of Ativan (0.5 mg) as well as a PRN dose (0.25 mg), but continued with behavior [agitation, running around too fast in wheelchair, running into residents, staff and all things] and that R55 was redirected many times without success.</p> <p>* 7/16/15 (9:24 PM) nurses' note documented prn Ativan was not effective and R55 continued to run over residents feet with wheelchair and running into other residents, unable to redirec. Was at risk to self / others due to being aggressive. Supervisor informed.</p> <p>7/16/15 (10:30 PM) late entry nurses' note documented contacting physician regarding continuing behavior after PRN Ativan. No new orders. Nurse documented that Ativan dose was decreased 7/10/15 due to POA request "until behaviors can be evaluated for medication dose efficacy".</p> <p>7/18/15 - blood pressure low throughout day. [There was no documented resident behaviors this day].</p> <p>7/20/15 (11:32 AM) nurses' note about discussion</p>	F 319		

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F 319	<p>Continued From page 27</p> <p>with physician and POA about R55's agitation and restlessness about possibility of increasing routine Ativan to three times a day if behaviors continue.</p> <p>7/22/15 - Physician note that R55's blood pressure and heart medications had been held for five days due the resident's low blood pressure and pulse. [There was no evidence that the resident experienced behaviors during the this time].</p> <p>7/31/15 (6:48 PM) nurses' note - right elbow skin tear.</p> <p>July, 2015 - MAR and nurses notes showed R55 received PRN Ativan 23 times (in addition to the routine dose scheduled twice a day) and nursing documented the medication had no effect on resident's behavior (12 times or 52.2%) or had partial effect (3 times or 13%).</p> <p>8/7/15 - Physician note documented hospitalization from 8/2/15 -8/7/15 for urinary tract infection, heart failure and irregular heart beat. Routine Ativan not ordered after the hospitalization, PRN Ativan 0.25mg every 8 hours continued.</p> <p>8/13/15 nurses' notes - found on floor at 7:25 PM with left elbow skin tear. Facility review of the security tape discovered R55 followed R126, an ambulatory resident, in his wheelchair and tried to run over his feet. R126 attempted to avoid the resident until R55 blocked the doorway to R126's room. When R55 attempted to grab R126 around the neck an altercation (grabbing and punching) occurred with R55 ending up on the floor. It is unclear why staff did not observe or</p>	F 319		

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F 319	<p>Continued From page 28 intervene in this situation.</p> <p>8/23/15 (10:09 PM) nurses note that resident had been intrusive with other residents after spouse left at 4:30 PM.</p> <p>August, 2015 - MAR and nurses notes showed the resident received PRN Ativan 4 times with 1 instance (25%) that nursing documented the medication had no effect on behavior and 1 times (25%) the medication had partial effect. The resident did not have an order for routine Ativan this month after hospitalization.</p> <p>9/2/15 - Behavior monitoring documentation on the MAR added the behavior of constant movement when in the wheelchair.</p> <p>9/3/15 - Physician order restarted routine Ativan 0.25 mg (half the strength ordered in the past) to be given once a day</p> <p>9/3/15 (10:34 PM), 9/5/15 (7:55 PM), 9/6/15 (8:02 PM), 9/12/15 (8:09 AM), 9/13/15 (4:48 PM) and 9/16/15 (4:00 PM) nurses' notes documented the resident required frequent / constant redirection to prevent injury to self or others.</p> <p>9/5/15 (10:31 PM) nursing note documented that "despite PRN and scheduled medications, resident continued to self-propel himself around the unit in the wheelchair, sometimes at an unsafe speed. He required very close monitoring while around other residents for fear that he would cause injury to their feet by running over them. He would bang into wheelchairs and other furniture, enter other residents' rooms and ransack them. Assisted to bed at 9:45 PM."</p>	F 319		

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F 319	<p>Continued From page 29</p> <p>9/13/15 (9:06 AM) PRN Ativan 0.25 mg - 3:25 PM "resolved, no further complaints sleeping" [grabbing, interfering with other residents].</p> <p>9/13/15 (12:05 PM) PRN Ativan 0.25 mg - "not as anxious". It was unclear why this dose was documented in the nurses' notes as being given only 3 hours after the earlier dose when the medication was ordered every 8 hours as needed . No resident behaviors were documented prior to this dose. The MAR does not indicate an Ativan was given at this time.</p> <p>9/16/15 (10:10 PM) nurses' note documented that at 6:45 PM R55 ran into the back of the legs/heels of another resident who was standing at the nursing station. Other resident did not incur any injury and R55 continued to propel with close-calls with other residents and staff. Required very frequent observation and diversion, but that intervention does not last. R55 continued to ransack other resident's rooms, intrusive behavior and unable to control boundaries. Physician informed of incident at 10:38 PM. No new orders. It is unclear how this situation occurred if frequent /constant redirection and/or supervision occurred.</p> <p>9/20/15 (6:06 PM), 9/21/15 (10:51 AM), 9/22/15 (6:45 PM), 9/28/15 (11:16 PM), 10/8/15 (9:59 PM) nurses' notes - resident required frequent / constant monitoring and/or redirection to prevent injury to self or others.</p> <p>* 9/28/15 (1:16 PM) nurses' note documented that after spouse left R55 returned to propelling at a fast rate needing near-constant prompting to keep from banging into others, frequently entering other residents' rooms.</p>	F 319		

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F 319	<p>Continued From page 30</p> <p>September, 2015 - MAR and nurses notes showed R55 received PRN Ativan 16 times and nursing notes documented 6 instances (37.5%) the medication had no effect on behavior and 2 instances (17.5%) with partial effect. In addition, starting 9/3/15, the resident received an Ativan 0.25 mg routinely once a day at 2:00 PM.</p> <p>10/2/15 - Physician order increased scheduled Ativan 0.25 mg to twice a day from once a day ordered on 9/3/15.</p> <p>10/8/15 observation between 3:00 PM - 3:30 PM the resident propelled very fast in the wheelchair using his feet and ran into residents in their wheelchairs and staff in the hallway as he went from the front exit door to the nursing station gate, then to the back exit door and returned to the front exit door.</p> <p>10/8/15 observation at 3:40 PM R55 grabbed the telephone cord on the back of the phone at the nursing station and pulled the phone toward himself. No staff was in the area. The surveyor told R55 the telephone was hooked to the wall, he looked at the surveyor then let go of the cord then wheeled away.</p> <p>10/9/15 observation between 10:20 AM - 11:40 AM during an activity held in the dining room R55 ran into the chair occupied by R103 several times when entering and exiting the room. R103 stated "If he does that one more time, I'll bop him" and touched her cane sitting on the table.</p> <p>10/13/15 observation at 9:52 AM - R55 propelled from the back hallway toward front exit door and ran into the wheelchair of another resident who</p>	F 319		

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F 319	<p>Continued From page 31 said "You better get away".</p> <p>10/13/15 Interview at 10:36 AM - E7 (UM) when asked how frequent / constant monitoring and redirection would be carried out on the gold unit the UM stated that frequent / constant monitoring and redirection would be implemented by passing information during shift change communication and the nurse would inform the staff of issues. To prevent R55 from entering other residents' rooms at night a fabric STOP sign would be placed to span across the doorway (attached with Velcro) as a deterrent. There was no mention about frequency of visual monitoring, placement of staff in the hallway, involvement by activities or social services. The use of the STOP sign was not included in the resident's care plan.</p> <p>10/13/15 observation 11:30 AM R55 entered the dining room and ran into R123's wheelchair. E26 (CNA) assisted R55 to navigate around the chair then talked to R55. Five minutes later R55 ran into R123's wheelchair again and got stuck when leaving the dining room . E26 assisted to push R 55 around the wheelchair.</p> <p>October 2015 - MAR and nurses notes through 10/11/15 showed the resident received PRN Ativan 5 times with nursing documenting that all doses (100%) had no effect on behaviors.</p> <p>10/13/15 observation at 10:06 AM - resident was taken off the unit to Bingo where he remained for 43 minutes.</p> <p>10/13/15 interview with E7 at 10:36 AM confirmed that Ativan was often not effective for improving the resident's behavior.</p>	F 319		

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F 319	Continued From page 32 43 out of 50 times (86%) the PRN Ativan was given, it was administered on the evening or night shift. Based on review of the clinical record during the period between 7/1/15 - 10/11/15, it is unclear how the facility evaluated the interventions in the resident's psychosocial adjustment care plan for social service to encourage the resident to express feelings as documentation of this is absent in the resident's record. It is also unclear if the physician was notified of the ongoing behaviors in the presence of medication adjustments. The effectiveness of the medication was lacking in the medical record since admission 5 months prior.	F 319		
F 323 SS=G	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 record review and interview it was determined that for 1 (R33) out of 48 sampled residents the facility failed to provide adequate supervision to prevent accidents. R 33 was brought to the nurses station for supervision after becoming restless and attempting to get out of bed. R33 experienced an unwitnessed fall from	F 323	1. A IDCC team meeting was held to discuss R33's plan of care. The care plan was updated to reflect clear, current approaches, safety interventions, measurable goals and provide guidance to staff. The primary intervention to address resident's restlessness at night	12/11/15

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F 323	<p>Continued From page 33</p> <p>the wheelchair causing her to hit her head on the floor and was transferred to the emergency room with complaints of head pain. R33 sustained significant swelling and bruising to her right cheek and eye. The facility failed to ensure the resident environment was as free of accident hazards as possible for 2 (1255 and 1211) out of 15 rooms observed. Findings include:</p> <p>1. The following documentation was reviewed in R33's medical record and other facility documentation:</p> <p>10/15/14 - Care plan for falls, high risk for injury from fall due to poor safety awareness and non compliance with safe transfers and attempts to get out of bed without assistance. The goal was minimal injury from falls. Approaches included; bed alarm when in bed for safety, low bed fall mats when in bed for safety, do not leave unattended, 2 or more assist with mechanical lift transfers, every one hour checks, observe for increased restlessness and anxiety inform nursing (5/19/15), clip alarm in bed at all times (6/12/15), clip alarm in chair at all times (6/16/15).</p> <p>1/25, 5/18, 5/23, 6/10, 6/11, 8/29/15 - Documented in the care plan evaluation falls from bed to floor mat next to bed without injury.</p> <p>3/25/15 - Care plan for behaviors did not provide guidance and interventions for staff when the resident becomes agitated and tries to get out of bed at night.</p> <p>6/12/15 - Quarterly MDS assessment documented severely impaired for decision making, extensive assistance of staff for transfers, does not walk and 2 or more falls with</p>	F 323	<p>is to spend 1:1 time in her room with the goal to try to get resident back to sleep. If resident's restlessness does not decrease, the nurse is notified. The nurse will decide if resident will get out of bed and nursing judgement will determine the level of supervision needed to ensure resident's safety. Other approaches in the fall care plan include managing resident's pain and continuing use of safety devices and equipment. The nursing department acknowledges the self-release seatbelt is a restraint.</p> <p>2. All residents that exhibit restlessness during the night and are gotten out of bed have the potential risk of not being properly supervised. A new process has been implemented to address this concern. CNAs will notify the nurse when a resident exhibits restlessness during the night. If the resident is gotten out of bed, nursing judgement will dictate the level of supervision needed to ensure resident's safety. The nurse will notify the nursing supervisor of the behavior and intervention used. Mandatory hour long training sessions were provided by the staff education department on 12/2/15, 12/3/15, 12/4/15, 12/9/15 and 12/10/15 (multiple sessions offered daily) to outline this new process.</p> <p>3. All nighttime restless behaviors will be communicated to the unit manager via the 24 hour report. The behavior will be discussed in morning meeting and the IDT will decide what approaches and goals are appropriate for the resident. The unit manager/designee will conduct random audits (R2) of nightly behavior</p>	

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F 323	<p>Continued From page 34 no injury since last review.</p> <p>9/6/15 - Facility incident report documented a fall at 5:00 AM in the hallway from the wheelchair, resident hit her head with swelling and moderate pain. The fall was documented as not being observed and the alarm was sounding. The resident was transferred to the emergency room.</p> <p>There were no nurses' notes documenting the details of the fall on 9/6/15 and there was no documented assessment of the resident following the fall and prior to R33's return from the hospital.</p> <p>9/6/15 - Facility witness statement from E11 (LPN) documented "I went into the med [medication] room to retrieve something for another resident around 5:00 AM or a little before. (Name of R33) was sitting quietly in her wheelchair in front of the nurses' station. Soon after entering the med room, I heard a personal alarm sound. I immediately left the med room to see the resident lying upon her right side with her leg caught up in her foot rest. The left foot rest had come off her chair...she was expressing 'it hurts'....then placed ice on her right cheek which was red and very swollen. She was able to move all her extremities and expressed that her head hurts".</p> <p>9/6/15 - Facility witness statement from E12 (LPN) documented that she was in another resident's room at the time of the fall. She described seeing another nurse over the resident and the resident with severe swelling noted to the right side of the face.</p>	F 323	<p>documentation for restlessness twice each week on their unit to ensure the proper procedure was followed and the care plan was updated. If the audit reveals a discrepancy then further education will be provided by the training department.</p> <p>4. The audits will be submitted and reviewed monthly by the nursing QA committee. Discrepancies will be addressed through training and further discrepancies will be addressed through disciplinary measures. The audits will continue for two consecutive months until 100% compliance is reached.</p> <p>Part II (Grab Bar)</p> <ol style="list-style-type: none"> 1. Immediate repair of the toilet grab bar in room 1255-1 and the towel bar in room 1211-2 was completed 10/14/15 once notified by surveyor. 2. All residents have the potential of being affected by a loose grab bar/towel bar. A sweep of every resident's room was made on 10/14/15 to identify loose grab/towel bars. Repairs to identified items were made. 3. The measures that will be put in place to ensure that the deficient practices do not recur are: <ol style="list-style-type: none"> a. Educate and initiate with housekeeping and nursing to identify daily loose grab bars and towel bars and report these items to our computer work order maintenance system for repair. b. Increase maintenance rounds to 		

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F 323	<p>Continued From page 35</p> <p>9/6/15 1:19 PM - nurse's note documented that the resident returned from the emergency room at 7:50 AM with a large bruise to the right eye, small bruise to the right 4th and 5th fingers and a 2 cm bruise to the left forearm. The note also stated the resident continued to try to get out of the wheelchair most of the day requiring frequent to, at times, near constant redirection and near constant supervision resulting in a near one-to-one status.</p> <p>9/6/15 2:52 PM - nurse's note documented that bruises appeared rapidly as the day went on from the fall. CNA reported when they put her to bed the resident had a bruise on her left hip.</p> <p>Review of the CNA Assignment Sheet active on 9/6/15 lacked instruction on what to do if the resident was agitated and wanted to get out of bed at night. The Assignment sheet provided instruction for staff to report to the nurse if resident was not calm for an afternoon nap and for the resident to attend an afternoon activity if not restful. These instructions failed to include interventions for staff to use at night when R33 was agitated.</p> <p>9/8/15 - Post fall interventions noted in the facility investigation included: clip alarm to wheelchair, therapy evaluation for wheelchair positioning, medication changes, hipsters and review of medication times. These approaches were not added to the care plan.</p> <p>9/11/15 8:41 PM - Therapy evaluation documented that the resident's wheelchair back was lowered to make it more difficult for the resident to stand and a new anti-trust (wedged)</p>	F 323	<p>weekly to identify loose grab bars and towel bars in resident rooms.</p> <p>4. The superintendent of the facility will monitor the work of the maintenance mechanics upon completion of work to ensure work is complete and acceptable and will be noted on the work order.</p>		

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F 323	<p>Continued From page 36 cushion was placed in the wheelchair.</p> <p>9/25/15 6:57 AM - nurse's note documented resident was up nearly all night cursing, repetitive speech, grabbing, wanting to leave. Staff took turns doing 1:1 for resident's safety. Medical (sic) made aware by written notification.</p> <p>9/28/15 - Facility incident report documented that at 5:10 AM R33 had an unwitnessed fall from the wheelchair to the floor with no apparent injury. This fall occurred while the resident was again left at the nurses' station.</p> <p>9/28/15 - Witness statement from E13 (RN) documented that she was getting a resident's medication out of the med (medication) cart, heard clip alarm sound and turned to see the resident roll to the side on the floor in front of her wheelchair.</p> <p>10/14/15 8:41 AM - E14 (RN) provided a statement from her security video viewing and from her conversation with E12 the 11 PM -7 AM nurse on 9/6/15. She stated that they (facility staff) did not know the approach to not leave the resident unattended was on the care plan. She further stated that the facility has identified issues with care planning development and would be doing a process improvement plan. E14 also stated that facility staff were removing the approach to not leave the resident unattended from the care plans since that would require a resident to be on 1:1 supervision. Surveyor review of the facility's security video, documenting the events of R33's fall of 9/6/2015, revealed that R33 was left at the nurses' station unattended and fell from her wheel chair.</p>	F 323		

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F 323	<p>Continued From page 37</p> <p>The facility statement from E12 documented that R33 was gotten out of bed and placed at the nurse's station because the resident had been attempting to get out of bed unassisted. E12 stated that R33 frequently attempts to get out of bed unassisted in the early morning and that they placed her at the nurses' station where there were more staff members to keep an eye on her: E12 stated that nursing staff on the unit were aware of R33's fall history and they tried to make a extra effort to watch her.</p> <p>10/14/15 10:27 AM - E15 (RN, unit manager) stated it would be unrealistic to have an approach to not leave a resident unattended in a facility this size. She was unable to find an approach on the CNA Assignment Sheet for how to handle R33 when she became restless at night. She stated it would be her expectation to get the resident out of bed and try to address whatever concern the resident was having. She stated it would be appropriate to bring the resident to the nurses station since it was a high traffic area and the nurses and aides could keep an eye on her.</p> <p>10/14/15 10:42 AM - E2, (acting DON) revealed that staff might move the resident closer to the desk at night because there are 5 staff on duty and someone is usually there. E2 confirmed that it would have been safer to leave the resident in bed if she was not in the line of sight of staff.</p> <p>-On 9/6/15 R33 attempted to get out of bed unassisted and was put in her wheelchair and moved to the nurses' station; -The facility failed to follow the resident's care plan that had an approach to not leave the resident unattended;</p>	F 323		

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F 323	Continued From page 38 -The resident was left in the wheelchair without constant direct supervision and fell to floor with injury. R33 hit her head on the floor and sustained significant bruising and swelling to the right cheek and eye as well as bruising to the fingers, arm and hip; -Review of the facility's video pertaining to 9/6/15 showed the resident at the nurses' station unattended and without supervision; -On 9/28/15 the resident was again brought to the nurses' station when attempting to get out of bed and fell again when she was unsupervised. These findings were reviewed with E1 (NHA) and E2 on 10/14/15 at 3:30 PM. 2. Observations during the initial tour on 10/16/15 and on the environmental tour on 10/12/15 between 10:00 AM - 11:00 AM revealed: -Room 1255-1 left grab bar next to toilet was loose where grab bar screws into the wall -Room 1211-2 towel bar by shower was loose These findings were reviewed with E17 (Custodial Supervisor) on 10/12/15 at 3:00 PM and with E1 and E2 on 10/14/15 at 3:30 PM.	F 323			
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition	F 325		12/11/15	

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F 325	<p>Continued From page 39</p> <p>demonstrates that this is not possible; and</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>This REQUIREMENT is not met as evidenced by :</p> <p>Based on record review and interview it was determined that the facility failed to identify a severe weight loss and perform reweighs for 1 (R 55) out of 48 sampled residents. Findings include :</p> <p>8/17/12 facility policy entitled Weight Monitoring included that if a nurse identified a 5 pound weight difference from the previous weight, the nurse will request a re-weigh which is to be done within 24 hours.</p> <p>Review of R55's EMR revealed: 5/15/15 - R55 admitted to the facility, weight 187 pounds, height 71 inches, regular diet.</p> <p>5/28/15 - 6/1/15 - hospitalized</p> <p>6/12/15 - house supplement once a day.</p> <p>6/23/15 - weight 178.</p> <p>7/2/15 - weight 171 pounds. No evidence of a reweigh within 24 hours due to the previous weight being over a five pound difference.</p> <p>7/7/15 - weight 173 pounds.</p> <p>7/16/15 - house supplement increased to twice a</p>	F 325	<p>1. We cannot go back and change R55 □s documentation that was reviewed during the survey. R55□s dietary notes were corrected to reflect a severe weight loss. R55□s height was corrected to reflect his actual height. (Attachment 325 A & 325B)</p> <p>2. All residents have the potential to be affected by the facility□s failure to identify a server weight loss during the first three months after admission, the failure to document the resident□s correct height and to not have a reweight completed within 24 hours. An audit of all newly admitted residents during the past six months will be conducted by the dietician to ensure no other residents exhibited a severe weight loss that was not identified and to ensure all heights were correctly entered into the resident□s chart. (attachment 325C) Severe weight loss will be determined by comparing resident□s initial admission weight. If a severe weight loss is found, the dietician will notify the resident□s IDT so appropriate interventions can be implemented and the dietician will document the weight loss in the resident□s dietary progress note and care plan. If a discrepancy in resident□s</p>	

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F 325	<p>Continued From page 40 day.</p> <p>7/23/15 - weight 169 pounds (9.6% severe loss since admission).</p> <p>7/24/15 - house supplement increased to three times a day.</p> <p>8/1/15 - weight 166 pounds (11.2% severe loss since admission).</p> <p>8/2/15 - 8/7/15 hospitalized</p> <p>8/8/15 nurses note at 11:32 PM - resident continued with decreased oral intake, encouraged to eat, takes fluids without difficulty if persistent.</p> <p>8/11/15 - weight 159 pounds (15% severe weight loss since admission 3 months ago). There was no evidence in the record that this 15% weight loss was identified. The facility failed to identify a severe weight loss three months after admission.</p> <p>8/26/15 - diet mechanical soft with ground meat.</p> <p>9/1/15 - weight 165 pounds.</p> <p>9/11/15 dietary note at 8:56 AM - "significant" [was actually a severe weight loss] weight change with 7% weight loss in the past 3 months, currently maintaining weight lost during multiple hospitalizations. Eating well and accepting house supplement offered three times a day. Received physical feeding assistance during meals and was recently started on monthly weight due to weight maintenance at the lower weight.</p> <p>The weight loss of 7% did not include the 7 pounds the resident lost during the first month at</p>	F 325	<p>height is noted, the resident will be re-measured and the correct height will be documented.</p> <p>3. The dietician and the Unit Managers will be re-educated the Chief of Operations and the Director of Nursing using the federal regulation 325 and guidance on the proper way to identify severe weight loss. Review of the following: formula to determine weight loss, use of initial weight, definitions of significant and severe weight loss, facility expectations regarding internal notification /communications, consulting nursing and medical and implementing interventions. Severe weight loss will be determined by comparing resident's current weight to resident's initial admission weight. The dietician will maintain a current resident log to reflect weights obtained and will calculate weight changes to determine if severe weight loss occurred. The percentage of weight loss will be recorded on the resident log. During quarterly reviews, the dietician will review all nutritional assessments to ensure the resident's height is correctly documented . If a discrepancy is noted, resident's height will be re-measured. When a reweigh is required, the dietician will notify the unit manager by e-mail, request the reweigh in morning meeting and hand deliver a copy of the e-mail to the Unit Manager in morning meeting, The Unit Manager will be notified of his/her responsibility to ensure the reweights are completed within the 24 hour time frame.</p>	

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F 325	<p>Continued From page 41 the facility.</p> <p>9/14/15 Quarterly Dietary Note at 1:34 PM - eating 90% breakfast and lunch and 75% dinner. Accepts bedtime snack 6 out of 7 times and house supplement twice a day. Needs either physical assistance with feeding or cueing after set up. Height 74" [height was actually 71 inches]. Ideal body weight 190 pounds.</p> <p>9/15/15 - weight 164 pounds.</p> <p>10/1/15 - weight 157 (16 % weight loss from admission). No evidence of a reweigh within 24 hours due to the previous weight being over a five pound difference.</p> <p>10/8/15 - weight 156 pounds (16.6% weight loss from admission)</p> <p>10/9/15 Dietary Note at 1:32 PM - "significant" weight change of 5% weight loss in one month and a 9% weight loss in 3 months [this was actually a severe weight loss]. The loss occurring in the past 3 months was due to multiple hospitalizations [hospitalized once during the previous 3 months]. He was eating 80% of breakfast, 60% of lunch and dinner. Accepted his bedtime snack 7 out of 7 times it was offered and supplement three times a day. Will increase house supplements to four times a day with the 4 th one offered at 9:30 PM while resident is wide awake. Will start weekly weights.</p> <p>The weight loss of 9% did not include the 18 pounds the resident lost during the first two months at the facility.</p> <p>10/13/15 interview with E4 (Dietician) at 9:30 AM</p>	F 325	<p>4. Dietician will track weight loss and report any negative findings to medical and nursing team. Unit Managers/ designee will audit all newly admitted residents' weights weekly/monthly during the first three months of their admission to ensure weight monitoring is correct. The Unit Manager/designee will ensure resident's height is correctly documented by the dietician in the dietary progress notes. Unit Manager/designee will report their findings to the nursing QA committee until compliance is reached two consecutive quarters. The dietician will audit reweights to ensure they were completed within 24 hours, make any immediate corrections required and report findings to the quarterly QA committee until compliance is reached for 2 consecutive months. Incorrect findings will be reported to the Director of Nursing so that immediate correction can be implemented.</p>		

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F 325	<p>Continued From page 42</p> <p>- stated the resident was in and out of the hospital several times so the change in weight was not recognized since "so many MDS assessments were completed". E4 confirmed the height of 74 inches documented in the 9/14 quarterly note was not correct and changed the height in the computer.</p> <p>10/13/15 at 10:09 AM E4 said whenever weight loss was noted, she would email the physician and unit manager.</p> <p>10/13/15 at 10:30 AM E27 (LPN) stated it may be several days before the floor nurse would be notified about the weight change and by the time the weight gets completed, it may be up to 5 days later.</p> <p>The facility failed to: *identify a severe weight loss three months after admission. *did not conduct a reweigh within 24 hours on two occasions . *incorrectly recorded the resident's height.</p>	F 325		
F 329 SS=E	<p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any</p>	F 329		12/11/15

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F 329	<p>Continued From page 43 combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by :</p> <p>Based of record review and interview it was determined that the facility failed to ensure the drug regimen was free from unnecessary drugs for 1 (R55) out of 48 sampled residents. Findings include:</p> <p>Cross Refer F319 and F280, Example 3. Review of R55's clinical record revealed:</p> <p>Review of R55's care plan, nurses' notes and MAR, including behavior monitoring documentation, between 7/1/15 - 10/11/15 discovered no documentation that other pharmaceutical or non-pharmaceutical interventions were considered for this resident's behaviors.</p> <p>The resident continued to receive a medication for anxiety eventhough it was not consistently</p>	F 329	<p>1. We cannot go back and make any changes to R55s past medication management. An assessment of resident <input type="checkbox"/>s behaviors was completed by the medical team and adjustments were made to the medication regimen. APN will review behavior documentation and medication effectiveness biweekly. Findings will be discussed with medical director and communicated to nursing administration. Further adjustments to resident <input type="checkbox"/>s psychotropic medication to be approved by the medical director and resident <input type="checkbox"/>s psychiatrist will be consulted.</p> <p>2. All residents run the risk of exhibiting periods of increased anxiety and behaviors which may necessitate the initiation/continued use of psychotropic medication. When such a resident is</p>	

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F 329	Continued From page 44 effective. These findings were reviewed with E1 (NHA) and E2 (Acting DON) on 10/14/15 at 3:30 PM.	F 329	identified the nurse will notify the APN or medical director who will assess resident and consult with the resident's psychiatrist. Once measures to lessen the degree of anxiety and decrease the frequency of the behaviors are determined the plan of care will be implemented and communicated to nursing staff via IDCC and/or a physician order. Nursing will communicate any behavioral concerns to the medical team. 3. When a resident behavior is identified, nursing will initiate a 24 hour behavior worksheet for the purpose of monitoring the behavior. Mandatory hour long training sessions were provided by the staff education department on 12/2/15, 12/3/15, 12/4/15, 12/9/15 and 12/10/15 (multiple sessions offered daily) on completing the worksheet (Attachment 329B). The unit manager will review the behavior worksheets daily and discuss the behaviors and interventions with the IDT. The care plan will be updated by the RNAC to reflect resident's current behaviors and appropriate interventions. The unit manager, RNAC and medical team will meet weekly to review resident's behavior and determine an individualized current plan of care. 4. The behavior worksheets will be audited at the monthly nursing QA meeting for a period of three months to ensure that resident behaviors are communicated between the medical and nursing departments. Interventions will be reviewed for effectiveness and any discrepancies will be addressed through education and progressive discipline.		

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F 411 SS=D	<p>483.55(a) ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS</p> <p>The facility must assist residents in obtaining routine and 24-hour emergency dental care.</p> <p>A facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; may charge a Medicare resident an additional amount for routine and emergency dental services; must if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and promptly refer residents with lost or damaged dentures to a dentist.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview it was determined that for 1 (R120) out of 48 sampled residents the facility failed assist a resident in obtaining dental services. Findings include:</p> <p>Review of R120's record revealed:</p> <p>10/28/14 - R120 was admitted to the facility.</p> <p>10/28/14 - Medical note that resident has many missing teeth and gingivitis.</p> <p>11/10/14 - Admission MDS indicated the resident had no dental problems.</p> <p>11/10/14 - Care plan for potential alteration in dental status related to missing teeth with history of gingivitis, wears partial dentures. There was no approach to assist in obtaining dental care.</p>	F 411	<ol style="list-style-type: none"> 1. The Medical Director met with R120. (Attachment 411A) A dental consult was entered on 11/17/15. The scheduler is currently working to set up a dental consult with a dental provider to determine future course of action. 2. All residents have the potential to be affected by not receiving routine/ emergency dental services. RNACs will audit MDS section L annual assessment records for the past six month period to identify any dental issues noted and to ensure follow up was/is completed. 3. The following consult processing measure will be put in place to ensure that the deficient practices does not reoccur: The consult processing procedure will be as follows: <ol style="list-style-type: none"> i. The Operations Support Specialist on 	12/11/15

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F 411	<p>Continued From page 46</p> <p>1/16/15 - Medical notes documented that patient asked nursing to arrange a follow-up dental exam and that a dental consult was ordered. The note also documented that the resident was established with the (name of) clinic and was last seen 6/2014.</p> <p>3/26/15 - Medical note documented marked gingivitis of his remaining lower teeth.</p> <p>4/29/15 - Care plan evaluation stated that per a medical note the resident still had marked gingivitis of remaining lower teeth and was to be scheduled for a follow-up dental visit.</p> <p>7/28/15 - Care plan evaluation stated that the goal was not met per conversation with resident that he had partial dentures but they do not fit well and he does not wear them. He had several missing upper teeth and lower teeth in poor condition. He stated he did not have any pain but he would like a dental consult to assess his current status and use of partial dentures. Will follow-up with medical [sic].</p> <p>8/19/15 - Nurses note to order dental consult that was originally ordered 1/2015.</p> <p>8/25/15 - Medical note documented oral dental condition is quite bad with many missing teeth, broken remaining teeth with marked periodontitis. However the note went on to explain that due to described medical reasons the doctor and resident agreed not to pursue dental care.</p> <p>10/09/15 2:31 PM - Interview with E15 (RN, unit manager) revealed that the January order for a dental consult was never carried out so she re-</p>	F 411	<p>each unit will pull off the consults daily and enter on a spreadsheet located on the shared drive.</p> <p>ii. The transportation scheduler will check the spreadsheet daily and will enter results of scheduling attempts/ appointment date onto the spreadsheet. Non-emergency appointments will be initiated within 48 hours of receipt and emergency appointments will be initiated same day as received by the scheduler.</p> <p>iii. Unit Managers review physician orders daily and will verify the OSS made the entry on the spreadsheet and will conduct periodic reviews to ensure resident receives care.</p> <p>iv. Medical team will have access to view the spreadsheet to ensure follow up is completed.</p> <p>v. Consult recommendations will be reviewed and processed as appropriate by the medical team/unit managers.</p> <p>4. The Admissions Coordinator will ensure follow up is completed on any dental issue identified for a new resident through an audit. The Social Worker will ensure follow up is completed on any dental issue identified at the quarterly care plan meeting through an audit. The Admissions Coordinator and the Social Worker will report their findings to the QA committee. The RNAC will ensure follow up is completed on any dental issues identified during an annual assessment through an audit and report the findings to the nursing QA committee. Unit Managers and the medical team are responsible to ensure any dental concerns are followed</p>		

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F 411	Continued From page 47 wrote the consult order in August. It was further revealed that the doctor at that time did not want the consult done and the original order was written by another medical professional.	F 411	up on appropriately that are identified while providing routine care.	
F 428 SS=D	<p>These findings were reviewed with E1 (NHA) and E2 (acting DON) on 10/14/15 at 3:30 PM.</p> <p>483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON</p> <p>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</p> <p>This REQUIREMENT is not met as evidenced by :</p> <p>Based on record review it was determined that the facility failed to ensure that the pharmacist reporting of irregularities was acted upon in a timely manner by the attending physician for 1 (R 56) out of 48 sampled residents. The pharmacist's request for a behavior diagnosis clarification in August, 2015 was not addressed until after the pharmacist's second request in September, 2015. Findings include:</p> <p>Review of R56's Pharmacy Medication Regimen Review dated 8/27/15 the pharmacist documented that the requested behavior and diagnosis be clarified.</p>	F 428	<p>1. The Consulting Pharmacist's recommendation to the Medical Team for a behavior diagnosis clarification for the antipsychotic medication that R56 was on had not been addressed until after the Pharmacist had submitted a second Note to Attending Physician/Prescriber (Attachment 428A).</p> <p>2. All Residents on any medication are at risk for a Consulting Pharmacist's recommendation to not be addressed in a timely manner. Prior to this Survey, a Procedure for Pharmacy Recommendations had been developed (</p>	12/11/15

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F 428	Continued From page 48 9/1/15 and 9/2/15 progress notes by E9 (NP) recorded blood test results and blood pressure readings. 9/14/15 progress note by E10 (Physician) included a medication review listing diagnoses for each medication including dementia (two drugs for Alzheimer's disease and an antipsychotic). Dementia is not an appropriate diagnosis for an antipsychotic. 9/15/15 progress note by E9 recorded a possible cause for R56's abnormal liver blood test and ordered the test to be repeated. 9/18/15 progress note by E9 documented the resident received two units of packed red blood cells for a disorder affecting R56's blood count. 9/21/15 the pharmacist repeated the request to clarify the behavior diagnosis on the Pharmacy Medication Regimen Review. 9/21/15 order included the clarification that the antipsychotic medication was to be given for behaviors associated with dementia-related psychosis. Psychosis is an appropriate diagnosis for an antipsychotic. The pharmacist's request for a behavior diagnosis clarification in August, 2015 was not addressed until after the pharmacist's second request in September, 2015. Findings were reviewed with E1 (NHA) and E2 (acting DON) on 10/14/15 at 3:30 PM.	F 428	Attachment 428B) and implemented. 3. An addendum has been added to the above Procedure that if the Note to Attending Physician/Prescriber is not received within 7 days, the MRT will contact the Medical Team and remind them that it is overdue. 4. This will be monitored by the MRT and ADON/Designee via the spread sheet maintained by the MRT. This is also monitored by the Pharmacist upon the next visit to that specific Unit. The Consulting Pharmacist will continue to report at the Quarterly QA Meeting whether all recommendations have been addressed		
F 441	483.65 INFECTION CONTROL, PREVENT	F 441		12/11/15	

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F 441 SS=F	<p>Continued From page 49 SPREAD, LINENS</p> <p>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.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p>	F 441		

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F 441	<p>Continued From page 50</p> <p>This REQUIREMENT is not met as evidenced by :</p> <p>Based on review of other facility documentation and interview it was determined that the facility failed to handle and process linens to prevent the spread of infection. Findings include:</p> <p>10/13/15 (11:20 AM) - During observation of the laundry facilities did not reveal any current temperature logs. Interview with E28 (Maintenance staff), confirmed she was not aware of temperature monitoring of the washing machines by the vendor and would only call the vendor when there were issues with washers.</p> <p>There was no evidence of temperature monitoring of the water in the washing machines.</p> <p>This finding was reviewed with E1 (NHA) and E2 (acting DON) on 10/13/15 at 3:30 PM at which time E1 stated the temperature of hot water from the tankless water heaters are monitored by maintenance.</p>	F 441	<ol style="list-style-type: none"> 1. The findings by the survey team on 10/13/15 did not directly affect any residents as the Delaware Veterans Home does not handle or process linens. This service is contracted with AP Linens Inc. located at 713 S Washington St. Milford, DE @ 302-430-0851. 2. All residents would potentially be affected by lack of monitoring of water temperatures if the facility handled and processed the linens, however the facility does not. It has been confirmed with AP Linens that they do monitor the temperatures and they are 160+ degrees and spread of infection is prevented by using hydrogen peroxide for healthcare facilities. 3. AP Linens, Inc. provided reports(Attachment 441A) confirming the vendor has a process in place for maintaining temperatures and completes inspections pertaining to their Boilers for the purpose of maintaining the 160+ temperatures and proper chemical distribution (Hydrogen peroxide) per load to ensure the spread of infection is prevented. AP linen has been directed in writing of our requirement that any failures to maintain temperature or required level of chemical, the facility must be notified and the linen reprocessed prior to being returned to the facility. Laundry staff has been educated on the process used by vendor to ensure proper sanitation. Additionally, laundry 	

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085051	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/14/2015
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F 441	Continued From page 51	F 441	<p>staff now checks the chemical distribution system and the water temperature daily logs findings/report noncompliance for resident clothing wash processed at the facility.</p> <p>4. Delaware Veterans Home will receive a Quarterly report from the vendor to ensure adequate monitoring and services are maintained to ensure future compliance. The Superintendent will monitor laundry staff compliance of daily recording of temperature and chemical system prior to 10 am Monday - Friday. The Superintendent will report findings to the QA Administrator quarterly.</p>		