

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

PRINTED: 11/24/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085053	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/10/2015
NAME OF PROVIDER OR SUPPLIER CADBURY AT LEWES		STREET ADDRESS, CITY, STATE, ZIP CODE 17028 CADBURY CIRCLE LEWES, DE 19958	
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F 000 INITIAL COMMENTS

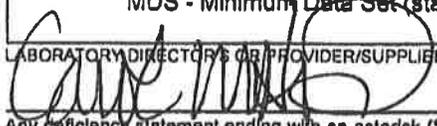
F 000

An unannounced annual survey was conducted at this facility from November 3, 2015 through November 10, 2015. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 40. The Stage 2 sample totaled 19 residents.

Abbreviations used in this report 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;
- RD - Registered Dietitian;
- NP - Nurse Practitioner;
- PA - Physician Assistant;
- DRS - Director of Resident Services;
- 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;
- MDS - Minimum Data Set (standardized)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE



TITLE

Executive Director

(X9) DATE

1/6/16

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 assessment used in nursing homes); ROM - Range of motion, extent to which a joint can be moved safely; HS - At bedtime; D/C - Discontinue; cm - cubic centimeters (unit of measurement); GDR - gradual dose reduction; 0 - 10 Pain Scale - number scale to rate pain where 0 is no pain and 10 is the worst possible pain; AIMS (Abnormal Involuntary Movement Scale) - test to determine presence of side effects to antipsychotic medication; Antipsychotic - drug to treat psychosis and other mental/emotional conditions; Anxiety - general unpleasant state of feeling worry, nervous or restless; Anxiolytic - medication used to treat anxiety; Aphasia - neurological condition in which language function is defective or absent; Ativan - medication to treat anxiety; Blood Pressure - measure of the force of the blood against the walls of a blood vessel; Buttock-fleshy part that forms the lower rear of the human body; Dementia - severe state of cognitive impairment characterized by memory loss, poor judgement, disorientation and/or personality changes; Heparin - blood thinning medication; Hospice - service that provides care to residents that are terminally ill; Klonopin - medication used to treat anxiety; Lorazepam - medication used to treat anxiety; Morphine: medication used to treat pain; Narcotic-drugs which dull the senses; Parkinson ' s Disease - a progressive disorder of the nervous system that affects your movement or a disorder of the brain that leads to shaking (tremors) and difficulty with walking, movement,	F 000	

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F 000	Continued From page 2 and coordination; Pre-before; Post-after; Pressure Ulcer - sore area of skin that develops when the blood supply is cut off due to pressure; Prognosis-the predicted course of a disease; Psychosis - loss of contact/touch with reality; Psychotropic - medication used to treat psychosis; Pulse - heart rate, the number of times the heart beats in one minute; Sacrum - tailbone; Seroquel - medication used to treat psychosis; SE-staff educator; Suspected Deep Tissue Injury - purple or maroon intact skin indicating tissue damage below the surface; Tramadol - pain medication; Wong-Baker FACES Pain Rating Scale - instructions for this pain scale included to explain that each face is for a person who has no pain, some pain or a lot of pain. Face 0 does not hurt at all, face 2 hurts just a little more, face 4 hurts a little bit more, face 6 hurts even more, face 8 hurts a whole lot and face 10 hurts as much as you can imagine. Although you don't have to be crying to have this worst pain. Ask the person to choose the face that best depicts the pain they're experiencing; Zyprexa - medication used to treat psychosis. F 156 483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES SS=E	F 000	F156 483.10(b)(5) - (10), 483.10(b)(1) F 156 NOTICE OF RIGHTS, RULES, SERVICES, CHARGES A. The facility has posted a written description of resident's legal rights and the contact numbers of all pertinent State client advocacy groups including the Division of Long Term Care Resident Protection.	11/06/15

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F 156	<p>Continued From page 3</p> <p>facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5) (1)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's</p>	F 156	<p>B. All staff members and residents have been notified regarding the contents of the sign along with the location of the sign.</p> <p>C. All staff are in-serviced by the Staff Developer regarding resident rights and where contact information is posted. All residents are informed regarding their legal rights and exactly where the information is posted by the Staff Developer.</p> <p>D. A Quality Improvement audit will be completed weekly by the ADON for 4 weeks and then monthly for 4 months to ensure 100% compliance of the posting remaining intact. All findings will be reported at the Quarterly Quality Improvement Committee Meeting by the ADON to ensure solutions are permanent (Attachment A).</p>	<p>11/19/15</p> <p>11/19/15</p> <p>12/30/15</p>

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F 156	Continued From page 4 non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to post the names, addresses and	F 156	

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F 156	Continued From page 5 telephone numbers of all pertinent State client advocacy groups including the Division of Long Term Care Residents Protection (DLTCRP) and the Ombudsman. Findings include: An observation on 11/9/15 at 8:18 AM revealed the absence of postings of contact information for the DLTCRP and the Ombudsman's offices for residents, visitors and staff. Findings were confirmed with E2 (DON) during an interview on 11/9/15 at 2:28 PM. Findings were reviewed with E1 (NHA) and E2 during the exit conference on 11/10/15 at 11:40 AM.	F 156	
F 167 SS=F	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to have their Survey Results available for examination in a place readily accessible to all residents and visitors and they failed to post a notice of their availability. Findings include:	F 167	F167 483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A. Survey results have been posted in an area that is readily accessible to all residents and visitors. A notice has been posted in the lobby of the health care center regarding the location of the survey results. 11/06/15 B. All residents and staff have been informed of availability and location of survey results. 11/19/15 C. All staff will be in-serviced by the Staff Developer regarding survey results and location of survey information. The DON/designee will check the survey results with a monthly audit to ensure that survey results are posted correctly. 11/19/15 D. A Quality Improvement audit will be completed monthly for 4 months or until 100% compliance is met for 3 consecutive months. Findings will be reported at the Quarterly Quality Improvement Committee Meeting by the DON/designee to ensure solutions are permanent (Attachment B). 12/30/15

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F 167	Continued From page 6 An observation on 11/3/15 at 9:02 AM revealed that the last four years of the facility's Survey Results were located in separate binders in a plastic luolite holder approximately 65 inches above the floor and attached to the wall next to the nurse's station. The Survey Results were inaccessible to wheelchair bound residents due to the holder's location at standing height level. In addition, there were no notices posted of the facility's survey results location and availability on the second floor, the health care center entrance or at the facility's main entrance. Findings were confirmed with E2 (DON) during an interview on 11/9/15 at 2:27 PM. Findings were reviewed with E1 (NHA) and E2 during the exit conference on 11/10/15 at 11:40 AM.	F 167		
F 242 SS=E	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to ensure self determination as a resident's right to make	F 242	F242 483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES A. A shower schedule was reviewed with R11's family and they have agreed to the shower schedule. B. A focus review was completed on all current residents by the charge nurse to ensure that all personal hygiene has been implemented. All residents are interviewed upon admission by the charge nurse regarding their preference for a shower or bath. A nurse will verify that a shower or bath was completed and documented on the TAR on assigned days (Attachment C). This review and monitoring will be completed by the charge nurse/ADON.	11/27/15 11/19/15

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F 242	<p>Continued From page 7</p> <p>choices about aspects of his or her life in the facility that are significant to the resident for one (R11) out of 19 sampled residents specifically in the area of bathing. This failure occurred on multiple occasions for R11. Findings include:</p> <p>Review of R11's clinical record revealed the following;</p> <p>7/24/15-Review of an annual MDS assessment documented R11's preferences for choosing between a tub bath, shower, or bed bath as somewhat important.</p> <p>Review of R11's clinical record revealed, R11 was scheduled to receive showers every Sunday and Wednesday on the 3-11 shift.</p> <p>Review of the CNA records and TAR signed by the nurses that documented when R11 received her scheduled showers indicated missed showers on the following dates: -8/9/15 , the previous shower being 8/5 and next being 8/12, a 7 day span between R11's showers. -7/19/15 the previous shower being 7/16 and the next being 7/22, a 6 day span between showers. -7/29/15 the previous shower being 7/26 and the next being 8/2, a 7 day span between showers.</p> <p>On 11/3/15 at 2:35 PM during an interview with the family member for R11, when asked does R11 receive the same number of baths or showers in a week based on past preferences, R11's family member answered "No, I think it's just once a week, I would like to see it more, It was more at home".</p> <p>During an interview on 11/09/15 at 10:23 AM with E12 CNA, it was confirmed that R11 was</p>	F 242	<p>C. All nursing staff will be in-serviced by the Staff Developer regarding shower/bath care schedules with emphasis on resident choice and completion of documentation. Random checks by the charge nurse on 3-5 residents per week will be completed for 4 weeks to ensure resident's shower schedule is being followed for consistency and accuracy.</p> <p>D. A Quality Improvement audit will be completed by the DON/ADON weekly for 4 weeks and then monthly for 4 months or until 100% compliance is met for 3 consecutive months. The audit will monitor the documentation of the shower schedule by the CNA and charge nurse. The audit will be reported to the Quality Improvement Committee by the ADON to ensure solutions are permanent (Attachment D).</p>	11/19/15 12/30/15

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F 242	Continued From page 8 scheduled to receive two showers per week. During an interview on 11/09/15 at 10:29 AM with E2 DON, it was confirmed that clinical record indicated that R11 did not receive her showers, as evidenced by absence of CNA and Nurse signature. R11 herself during MDS assessment, and with confirmation from her family members through interview expressed a preference for bathing. The facility failed to provide the necessary assistance to help R11 fulfill her choice for showers as evidenced by the number of documented missed showers. Findings were reviewed with E1 (NHA) and E2 on 11/10/15 at 11:40 AM.	F 242		
F 244 SS=E	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility documentation and interviews, the facility failed to act upon a grievance and recommendation from the resident council group concerning operational decisions affecting life in the facility. Findings include:	F 244	F244 483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE / RECOMMENDATION A. The addressed concern and activity time has been adjusted to allow more time in group activities. B. The new activity calendar has been posted reflecting additional time for group activities. All residents will be notified regarding additional time/activity during the December 8, 2015 Resident Council Meeting (Attachment E). C. All staff has been in-serviced regarding new activity times by the Activity Director. The Activity Director/designee will perform random audits to ensure the new times are implemented according to the schedule. The Activity Director will review all grievances to ensure compliance has been met.	12/01/15 12/01/15 11/19/15

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F 244	<p>Continued From page 9</p> <p>The 6/30/15 resident's council meeting minutes stated that activity time is too short and requested a longer activity time.</p> <p>The 7/28/15, 8/25/15 and 9/22/15 Resident Council meeting minutes lacked evidence of the facility addressing the group's activity grievance.</p> <p>In an interview on 11/5/15 at 11:00 AM, R22 stated that the residents in activities feel rushed, especially during the afternoon activity that starts at 2 PM and ends promptly at 3 PM. R22 stated that activities in the skilled activity room are routinely held from 10 to 11 AM and 2 to 3 PM. R22 stated the activity room was also used as a dining room for dependent residents. Since dining service requires time to set up for the next meal, the activities are time limited. It was unclear why the facility's 2 PM afternoon activity ended promptly at 3 PM when dinner service started at 5 PM.</p> <p>An observation on 11/5/15 at 3 PM revealed that the afternoon activity in the skilled activity room ended promptly at 3 PM.</p> <p>In an interview on 11/9/15 at 1:50 PM, E11 (DRS) stated that extending the afternoon activity time was brought to her attention by R22 after interview with the surveyor. E11 stated the facility will extend the activity time starting next month, December 2015. It was unclear why it took the facility five (5) months to act upon the Resident Council's grievance from June 30, 2015.</p> <p>Findings were confirmed with E11 on 11/9/15 at 1:50 PM. The facility failed to act upon a grievance and recommendation of the Resident Council to extend the afternoon activity time.</p>	F 244	<p>D. A Quality Improvement audit will be performed by the Activity Director monthly for 6 months or until 100% compliance is met for 3 consecutive months to ensure hours of satisfaction for residents' group activities. Results of the audit will be reported at the Quarterly Quality Improvement Committee Meeting by the Activity Director to ensure the solution is permanent (Attachment F).</p>	12/30/15

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F 244	Continued From page 10 Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 11/10/15 at 11:40 AM.	F 244		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation it was determined that the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior in 12 (201, 212, 214, 216, 217, 219, 220, 221, 224, 229, 236, and 237) out of 40 rooms. Findings include: -torn fall mats in 214, 216, 219, and 220 -damaged walls, doors and door frames in 201, 219, 220, 224, 229, 236, and 237 -bathroom lights and night lights in need of repair or cleaning in 217, 221 and 224 -loose electrical and call light wall plates in 212, 216, and 219 Findings were reviewed with E9 (Director of Support Services) on 11/9/15 at 9:10 AM. Findings were reviewed with E1 (NHA) and E2 (DON) on 11/10/15 at 11:40 AM.	F 253	F253 483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES A. The torn fall mats were removed and replaced with new ones in all rooms. The damage to the walls and doors were repaired in all rooms. The lights and night lights were replaced in each room identified. The loose electrical and call light plates were repaired in each room identified. B. All other rooms were inspected and work requests were placed for any issues. C. All staff has been in-serviced by the Director of Support Services regarding the importance of checking and replacing/repairing torn mats and any damage to the walls and doors. An inspection sheet has been developed for the housekeepers to use to perform weekly checks on the condition of all fall mats, walls and doors, proper operating lights and night lights, and loose electrical and call light plates. The findings of the audit will be reported weekly to the Director of Support Services for consistency and accuracy. D. The Housekeeping Team Leader will perform random inspections of rooms weekly for 4 weeks and then monthly for 6 months or until compliance is 100% for 3 consecutive months. Findings will be reported at the Quarterly Quality Improvement Committee Meeting by the Director of Support Services (Attachment G).	11/09/15 11/09/15 12/10/15 12/30/15
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED	F 278		

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

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FORM APPROVED
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085053	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/10/2015
NAME OF PROVIDER OR SUPPLIER CADBURY AT LEWES		STREET ADDRESS, CITY, STATE, ZIP CODE 17028 CADBURY CIRCLE LEWES, DE 19958	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE
F 278	<p>Continued From page 11</p> <p>The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews, it was determined that the facility failed to ensure the accuracy of MDS assessments for 2 (R24 and R74) out of 19 sampled residents. For R24, the facility failed to accurately reflect the resident's falls. For R74, the facility failed to accurately reflect the resident's prognosis on two MDS assessments. Findings include:</p>	F 278	<p>F278 483.20(g) – (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED</p> <p>1.</p> <p>A. R24's MDS was corrected to reflect the accurate number of resident falls. 11/05/15</p> <p>B. All resident MDS' have been reviewed by the RNAC/DON to ensure that all documentation is complete and all coding is appropriate by 11/13/15. All future MDS' will be coded correctly to reflect all residents with falls. Random checks by the RNAC/ADON will be completed weekly on 3 residents to ensure that all residents with falls and MDS coding are complete. 11/13/15</p> <p>C. All staff will be in-serviced by the Staff Developer regarding MDS coding of falls and the appropriate documentation required to ensure documentation is accurate and consistent. 11/15/15</p> <p>D. A Quality Improvement tool monitoring documentation of falls and MDS coding will be completed weekly for 4 weeks and then monthly for 4 months or until 100% compliance is met for 3 consecutive months to ensure documentation and coding is accurate by the DON/designee. All findings will be reported at the Quarterly Quality Improvement Committee Meeting by the DON/designee (Attachment H). 12/30/15</p>

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

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NAME OF PROVIDER OR SUPPLIER CADBURY AT LEWES		STREET ADDRESS, CITY, STATE, ZIP CODE 17028 CADBURY CIRCLE LEWES, DE 19958	
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F 278	<p>Continued From page 12</p> <p>1. R24 was admitted to the facility on 10/16/15.</p> <p>Review of the clinical record revealed that R24 had falls without injury on 10/17/15 and 10/18/15.</p> <p>The admission MDS assessment, dated 10/23/15, revealed that R24 had one fall without injury.</p> <p>During an interview on 11/9/15 at 10:57 AM, E4 (RNAC) confirmed the finding. The facility failed to accurately reflect R24's falls when they coded one fall without injury on the 10/23/15 admission MDS assessment, when R24 actually had two falls without injury.</p> <p>Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 11/10/15 at 11:40 AM.</p> <p>2. 11/7/14 - Hospice initial certification documented prognosis under six (6) months while R74 resided in assisted living.</p> <p>3/10/15 - R74 admission to facility from assisted living on hospice.</p> <p>6/16/15 and 9/16/15 - Quarterly MDS assessments documented the resident did not have a prognosis under 6 months.</p> <p>11/9/15 -During an interview at 10:20 PM with E4 (RNAC) she stated that she would include the prognosis in the MDS if it were written in the chart by the physician. There was discussion that the prognosis must be under 6 months to qualify for hospice. E4 confirmed that two quarterly assessments did not document a prognosis</p>	F 278	<p>2.</p> <p>A. R24's attestation of prognosis of less than six months to live was identified on medical record. 11/05/15</p> <p>B. All residents with a diagnosis of a terminal illness per attestation will be checked by the RNAC to ensure that the resident's terminal diagnosis is reflected on the MDS. A weekly check by the RNAC for 4 weeks and then monthly for 4 months or until 100% compliance is met for 3 consecutive months with a monitoring sheet of 2-4 residents or 10% of the census will ensure that all documentation and coding is accurate. 11/13/15</p> <p>C. In-service of all nursing staff will be completed by the Staff Developer regarding MDS coding of attestation of terminal illness and appropriate documentation required to support diagnosis. 11/25/15</p> <p>D. A Quality Improvement tool will be completed monthly on all new admissions and ten residents for 4 months to ensure documentation is 100% compliant for 3 consecutive months. All findings will be reported at the Quarterly Quality Improvement Committee Meetings by the DON/designee (Attachment I). 12/30/15</p>

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 278	Continued From page 13 under 6 months. The facility failed to accurately document R74's prognosis on two quarterly assessments. Findings were reviewed with E1 and E2 on 11/10/15 at 11:40 AM.	F 278	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record reviews and interview, it was determined that the facility failed to develop individualized activity care plans based on the residents' comprehensive and activity	F 279 F279 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS	A. R-24 - The facility cannot retroactively adjust the care plan after resident has been discharged. R-56 – the care plan has been adjusted to reflect an individualized care plan according to the activity assessment. 11/19/15 B. A focus review of all residents will be completed and care plans adjusted accordingly. All new admissions will be assessed and preferences for activities will be accommodated. 12/19/15 C. All staff has been in-serviced regarding care plan documentation and individualization of resident care plan by the Staff Developer. The Activity Director will implement random audits of three charts per week of residents care plans to ensure individualization of resident needs have been met. 11/19/15 D. A monthly audit tool will be completed by the Activity Director monitoring the resident care plans weekly for 4 weeks and then monthly for 4 months or until 100% compliance is met for 3 consecutive months. Findings will be reported quarterly at the Quality Improvement Committee Meeting (Attachment J). 12/30/15

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

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F 279 Continued From page 14

F 279

assessments for two (R24 and R56) out of 19 Stage 2 sampled residents. Findings include:

The facility's activities policy, undated, stated, "The goal of the Activity Department is to encourage and support ... residents' individuality, dignity, spirituality and independence by creating an environment that reflects the residents' unique experiences, skills and interests ... We are committed to supporting the residents' specific abilities, spiritual beliefs and ethnic traditions in order to maintain their highest quality of life".

1. R24 was admitted to the facility on 10/16/15 for short term rehabilitation.

The Activity/Therapeutic Recreation Assessment, dated 10/21/15, revealed the following activities currently enjoyed by R24: arts and crafts, collecting, community activities, family activities, going outside, music, puzzles, social conversation and television.

R24's activity care plan, dated 10/22/15, stated, "I am in the facility's healthcare community to receive therapy. I am social and may need socialization and activity participation due to a change in my health status ...". R24's activity goals included: "To regain my strength and mobility through therapy. I will find opportunities for participating in activities of my choosing for socialization". R24's activity approaches included: "Activities will provide me with the monthly activity calendar. The activity staff can invite me to activities but honor my wishes if I do not want to participate. I would like activity cart visits two to three times per week offering me books, magazine, puzzles, crosswords & anything else that may be available".

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

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F 279	<p>Continued From page 15</p> <p>The admission MDS assessment, dated 10/23/15, stated that R24's activity preferences were the following: reading materials, music, news, going outside and religion.</p> <p>The facility failed to develop an individualized activity care plan based on R24's comprehensive and activity assessments.</p> <p>2. R56 was admitted to the facility on 8/24/13 and is currently a long term care resident.</p> <p>The facility's Assessment of Interests, Talents & Skills, dated 8/24/15, revealed R56's current interests included: bird watching, going outdoors, TV/news, Bingo, baseball, basketball, music, ceramics and flower arranging.</p> <p>The significant change MDS assessment, dated 7/3/15, stated that R56's activity preferences were: reading materials, music, animals, news, groups and going outside.</p> <p>R56's activity care plan, last revised on 10/3/15, stated, "... I am social and may need socialization and activity participation ... I have strong support from my daughter, who visits frequently". R56's goals were "I will find opportunities for participating in activities of my choosing for socialization. I will participate in group activities as often as possible. R56's approaches included: "Activities will provide me with the monthly activity calendar. The activity staff can invite me to activities but honor my wishes if I do not want to participate. If I am unable and refuse to attend group activities, I would like room visits two or three times per week".</p>	F 279	

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

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F 279	Continued From page 16 In an interview on 11/9/15 at 1:50 PM, E11 (DRS) stated that she oversees activities for the community, including independent living, assisted living and skilled nursing care. E11 stated that her activity coordinator completes the activity care plans for residents in skilled nursing care. E11 confirmed the findings that R24 and R56's activity care plans were not individualized according to their comprehensive and activity assessments. Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 11/10/15 at 11:40 AM.	F 279		
F 280	483.20(d)(3), 483.10(k)(2) RIGHT TO SS=D 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 and revised by a team of qualified persons after each assessment.	F 280	F280 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 1. A. The facility is unable to retroactively update R46's care plan related to resident's discharge on 11/05/2015. R74's care plan has been updated to reflect current physician's orders. B. All residents' wound care documentation has been reviewed to ensure that all goals have been updated and reflected in the care plan. The charge nurse will review the 24 hour report sheet to ensure that all care plans and goals have been updated accordingly. C. All nursing staff will be in-serviced by the Staff Developer regarding the procedure for updating care plan changes along with goals. All new wounds will have a documented wound alert and a new physician's order will be written for the treatment of choice. All new orders will be reviewed within 24 hours by the DON/ADON to ensure that all care plans changes have been made and to keep errors from happening again.	11/24/15 11/10/15 11/19/15

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

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F 280 Continued From page 18

3/12/15 physician progress note - Assessment/Plan for severe dementia documented changing R74's Zyprexa to Seroquel and monitoring response.

3/19/15 - Care plan problem for potential for side effects related to psychotropic drug use included undated handwritten entries naming two medications with their ordered dosing (Seroquel 12.5 mg twice daily and Klonopin 0.25mg every 12 hours). The goal of remaining free from adverse side effects from psychotropic drug therapy (Seroquel) also included an undated handwritten entry listing the medication Klonopin.

3/19/15 - Care plan problem for potential for adverse side effects related to medication for anxiety (Ativan gel yellowed out indicating it was discontinued and Klonopin was handwritten).

4/2/15 physician progress note - resident had multiple medicine changes in a short period of time, not long enough to determine a response, continue Seroquel and Klonopin.

10/5/15 - Physician order discontinued Klonopin and started Ativan to be given both routinely (scheduled) and PRN.

11/10/15 - Interview at 8:20AM with E5 (LPN) confirmed R74 was no longer on Klonopin but the care plan still included the drug under problems of psychotropic drug use and anxiety.

R74's care plan for psychotropic drug and anxiety included Klonopin even after it was discontinued the month prior.

Findings were reviewed with E1 and E2 on

F 280

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 280 F 309 SS=E	Continued From page 19 11/10/15 at 11:40 AM. 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations and interviews, it was determined that the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care for 4 (R8, R56, R74 and R141) out of 19 Stage 2 sampled residents. For R56, the facility failed to follow the plan of care of placing lids on her two handled cups for hot and cold liquids during four (4) meal observations. For R141, the facility failed to administer a medication ordered by the physician on two occasions. For R74, the facility failed to consistently assess the resident's pain using the same numeric score before and after PRN pain medication and failed to obtain vital signs as ordered by the physician. For R8, the facility failed to follow the physician order to discontinue a medication and failed to consistently assess the resident's pain using a numeric scale after PRN pain medication. Findings include:	F 280 F 309	F309 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 1. A. R141 – A medication error has been completed for the omitted doses on 10/28/15 and 10/29/15. The facility is unable to retroactively verify that the medication was given relating to the resident's discharge on 11/09/15. B. A focus review was completed on all resident's MAR to ensure that no doses were missed. A change of shift MAR check is completed by the nurses and signed for in the MAR to ensure that all documentation has been completed. C. All nursing staff will be in-serviced by the Staff Developer regarding the procedure for medication administration including the five rights and the importance of documentation on the MAR to reflect administration of the medication. The charge nurse will review the MAR at the end of each shift to ensure that all medication has been given and documented in the MAR. Random MAR checks will be completed by the ADON on 5-6 residents per week for 4 weeks to keep deficient practice from happening again (Attachment M). D. A Quality Improvement audit will be completed by the ADON weekly on 10 residents a week for 4 weeks and then monthly for 4 months or until 100% compliance is met for 3 consecutive months and reported to monitor the effectiveness of the change. Findings will be reported at the Quarterly Quality Improvement Committee Meeting by the ADON to ensure solutions are permanent (Attachment N).	11/30/15 11/10/15 11/19/15 12/30/15

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FORM APPROVED
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F 309	Continued From page 20 1. R56 was admitted to the facility with diagnoses including Parkinson's disease and dementia. R56's adaptive equipment care plan, last revised on 7/8/15, stated that she required a "2 handled lid cup for hot liquids and cold liquids". The Diet Order & Communication, dated 10/13/15, stated that R56 was ordered to have a "2 handled cup for hot/cold liquids with lid". R56's Parkinson's Disease care plan, last revised on 10/5/15, stated to "monitor need for safety interventions based on resident's symptoms of tremors ...". The following observations were made during the survey: - 11/5/15 at 8:16 AM, R56 was observed with two cold liquids at breakfast with straws, but no lids on the cups. R56 was observed leaning into the table to drink from the straw without picking up the cup. - 11/5/15 at 9:07 AM, R56's was observed with hand tremors while eating breakfast. - 11/5/15 at 12:07 PM, R56 was observed with two cold liquids at lunch with straws but no lids on the cups. - 11/5/15 at 5:11 PM, R56 was observed drinking a cold liquid in a cup with a lid while her hands were shaking. She was able to hold the lidded cup. However, the second cup with a cold liquid did not have a lid on it. - 11/9/15 at 8:45 AM, R56 was observed with	F 309	2. A. R74's pain level has been assessed utilizing the PAINAD scale and the resident has been medicated accordingly. B. All residents are assessed during each shift utilizing the Wong-Baker FACES Pain Rating Scale or the PAINAD scale and medicated accordingly. The PRN pain documentation sheet has been adjusted to reflect both pain scales needed to effectively assess all resident pain. All PRN medication has been documented accordingly (Attachment O). C. All nursing staff has been in-serviced by the Staff Developer regarding the adjusted pain scale documentation sheet and procedure. The charge nurse will review the PRN pain documentation at the end of each shift weekly for 4 weeks and then monthly for 4 months or until 100% compliance is met for 3 consecutive months to keep the deficient practice from happening again. D. A Quality Improvement audit will be completed by the ADON weekly for 4 weeks on ten residents and then monthly for 4 months or until 100% compliance is met for 3 consecutive months and reported quarterly to the Quality Improvement Committee by the ADON to ensure solutions are permanent (Attachment P). 3. A. R8 - A medication error was completed for the delay in following physician's order. B. All residents physician's orders have been reviewed to ensure orders have been initiated and completed. All orders will be reviewed during the 24 hour chart check and daily by the DON/designee for accuracy and consistency.	11/10/15 11/30/15 11/19/15 12/30/15 11/30/15 11/11/15	

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F 309	<p>Continued From page 21</p> <p>three cups in front of her for breakfast. Two of the three cups did not have lids on them, specifically the hot coffee and orange juice. E13 (CNA) was asked by surveyor what liquids were in each cup. E13 replied, "orange juice, water and hot coffee". The surveyor asked E13 if lids were supposed to be on all cups, and E13 replied, "I don't know, she uses straws". E13 walked over to the serving window and returned to R56's table with lids that did not fit the resident's other two handled cups. E14 (SE) walked over to R56's table and picked up the resident's meal slip and stated that R56 was to have a two handled cup with lid for all liquids (hot and cold). E13 immediately removed the lid from the filled water cup and placed it on R56's hot coffee cup.</p> <p>In an interview on 11/9/15 at 9:08 AM, E14 (SE) confirmed the findings. The facility failed to follow R56's plan of care of placing lids on her two handled cups for hot and cold liquids as evidenced by four (4) dining observations when lids were missing from the cups.</p> <p>These findings were reviewed with E1 (NHA) and E2 (DON) on 11/10/15 at 11:40 AM.</p> <p>2. R141 was admitted to the facility on 10/21/15 with diagnoses including high blood pressure.</p> <p>R141 was ordered Clonidine medication daily for high blood pressure.</p> <p>Review of the October 2015 MAR revealed that R141 was not administered Clonidine on 10/28/15 and 10/29/15.</p> <p>In an interview on 11/9/15 at 12:35 PM, E5 (LPN) confirmed the findings. The facility failed to follow</p>	F 309	<p>C. All nursing staff has been in-serviced by the Staff Developer regarding the policy and procedures of physician orders. 11/19/15</p> <p>D. A Quality Improvement audit will be completed by the DON/ADON weekly for 4 weeks ten residents a week and then monthly for 4 months or until 100% compliance is met for 3 consecutive months and reported to the Quality Improvement Committee by the DON/ADON to ensure solutions are permanent (Attachment Q). 12/30/15</p> <p>4.</p> <p>A. R56 has appropriate lids placed on her cups. 11/07/15</p> <p>B. All residents with orders for adaptive equipment have been reviewed to ensure care plan and equipment match and are accurate. The Dietary Department is in the process of transitioning to identical sippy cups with lids for all residents with orders for adaptive equipment. 12/05/15</p> <p>C. All nursing and dietary staff has been in-serviced by the Staff Developer on the importance of residents having the appropriate adaptive equipment in place as per physician's order. All new adaptive equipment has been ordered for all residents. Random checks by the Director of Dining/designee will be completed weekly for 4 weeks and then monthly for 4 months or until 100% compliance is met for 3 consecutive months to monitor the effectiveness of the change and ensure compliance and accuracy and consistency. 11/19/15</p>

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

PRINTED: 11/24/2015
FORM APPROVED
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F 309 Continued From page 23

F 309

3/10/15 - Admission orders included morphine every 8 hours (three times a day) routinely for pain along with morphine every 2 hours PRN for breakthrough pain.

5/11/15 - Physician order increased routine morphine to every 6 hours (four times a day) while the PRN morphine was unchanged.

The facility utilized a pain flow sheet as well as the standard MAR. The reverse or back of the MAR requires the nurse administering the pain medication to record the medication given, time administered location of the pain and the effectiveness of the pain medication. The effectiveness should be measured utilizing the same numerical scale that was used to rate the level of pain prior to administration of the medication. Review of the MARs and the Pain flow sheets revealed that the facility failed to consistently assess, utilize and document the level of pain after medication administration using the same scale as before medication administration.

Review of R74's MARs and pain flow sheets for the months of July, August, September and October 2015 revealed:
July, 2015 - 10 (ten) PRN administrations
- Reverse of MAR completed for 7 out of 10 administrations.
- Pain flow sheet completed for 4 out of 10 administrations, with 2 entries not including the numeric pain score pre and post PRN medication.

August, 2015 - 4 (four) PRN administrations

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

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F 309 Continued From page 24

F 309

- Reverse of MAR completed for 3 out of 4 administrations.
- Pain flow sheet completed for 2 out of 4 administrations, with both entries not including the numeric pain score pre and post PRN medication.

September, 2015 - 9 (nine) PRN administrations
- Pain flow sheet completed for 6 out of 9 administrations, with 2 entries not including the numeric pain score pre and/or post PRN medication.

11/9/15 Interview with E2 between 10:00 AM - 10:20 AM - E2 stated the expectation would be that the pain flow sheet be completed and not the back of the MAR when documenting the administration and effectiveness of PRN pain medications. It is unclear why this was the expectation when the facility maintained two tools for documentation.

- Resident acceptable pain score would be difficult to determine without resident input.

- When asked why some nurses determined a numeric pain score for R74 while other nurses did not, E2 said that determining the numeric score would be difficult since the resident cannot state a numeric score or point to the face scale. E2 stated the nurse could look at the resident's expression and compare it to the face scale for determination of a pain score. E2 would determine if a non-verbal scale was available in the facility. (Wong-Baker FACES Pain Rating Scale (this scale is similar to that used by the facility) instructions for use include explaining to the resident that each face is for a person who

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

PRINTED: 11/24/2015
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F 309 Continued From page 25

F 309

has no pain, some pain or a lot of pain and the resident should choose the face that best depicts the pain they're experiencing. There is no evidence to support the nurse could determine a pain score with this pain scale.]

11/9/15 - At 11:08 AM E2 provided the surveyor with a copy of the face scale but not a non-verbal scale. There was no evidence that the facility was utilizing a non-verbal pain scale. [Pain Assessment in Advanced Dementia Scale (PAINAD), developed in 2003, is a five-item observational tool to determine a pain score using facial expression, vocalization, body language and consolability. The final pain score will range from 0-10 where 0 is no pain and 10 is severe pain. Wharden V, Hurley AC and Volicer L. (2003) Development and psychometric evaluation of the Pain Assessment in Advanced Dementia (PAINAD) Scale. J AM Med Dir Assoc, 4(1), 9-15.]

It is unclear from review of the facility policy and record review how the facility could determine a pain score for R74 since the resident cannot state a numerical score or point to the facial rating scale.

The facility failed to consistently assess the resident's pain using an appropriate numeric score before and after PRN pain medication.

These findings were reviewed with E1 and E2 on 11/10/15 at 11:40 AM.

b. 3/10/15 - physician ordered BP and pulse (vital signs) weekly.

July, 2015 MAR - one (1) out of five (5), or 25%,

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

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F 309	<p>Continued From page 26 of vital signs were missing.</p> <p>August, 2015 MAR - three (3) out of four (4), or 75%, of vital signs were missing.</p> <p>9/9/15 - Physician ordered BP and pulse every shift for 10 days.</p> <p>September, 2015 MAR - seven (7) out of thirty (30) shifts, or 23%, were missing BP and pulse documentation. Weekly BP and pulse were recorded 5 times this month.</p> <p>October, 2015 MAR - one (1) out of four (4), or 25%, of vital signs were missing.</p> <p>11/9/15 - Interview at 10:00 AM with E2 confirmed the documentation was missing.</p> <p>The facility failed to consistently obtain R74's BP and pulse as ordered by the physician.</p> <p>These findings were reviewed with E1 and E2 on 11/10/15 at 11:40 AM.</p> <p>4. The following was reviewed in R8's clinical record:</p> <p>a. 10/15/15 -- Physician order stated "D/C Heparin since ambulating" (time of order not documented). However, review of the MAR showed Heparin was given 3 times at 9:00 AM, 2:00 PM and 6:00 PM.</p> <p>10/16/15 -- Verbal order stated "D/C Heparin" (time of order not documented). Review of the MAR showed Heparin was given 2 times at 9:00 AM and 2:00 PM.</p>	F 309	

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

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FORM APPROVED
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F 309	<p>Continued From page 27</p> <p>11/9/15 -- Review of the Twenty-four Hour Chart Check form in the clinical record, showed a nurse signature on 10/15/15 and 10/16/15 indicated the chart was reviewed on these dates but the Heparin orders were not transcribed onto the MAR.</p> <p>11/9/15 at 3:30 PM interviewed E5 (LPN) who confirmed there was no further documentation to show the Heparin orders were transcribed onto the MAR.</p> <p>These findings were reviewed with E1 and E2 on 11/10/15 at 11:40 AM.</p> <p>b. 8/1/15 - Physician order for pain medication every 4 hours as needed.</p> <p>Review of R8's MAR for the month of September 2015 revealed:</p> <ul style="list-style-type: none"> - No time of administration of pain medicine documented on MAR on 9/3, 9/4, 9/8, 9/9, 9/10, 9/11, 9/13, 9/17, 9/22 or 9/22/15. - Effectiveness of pain medication was not documented on the Pain and Efficacy of Intervention sheet in the clinical record on 9/6, 9/8, 9/9, 9/10, 9/11 and 9/13/15. - On 9/22/15, it was documented on the Pain and Efficacy of Intervention sheet that PRN pain medication was given at 8:45 AM and at 3:00 PM, however, there was only one Initial (no time) documented on the MAR. <p>11/9/15 at 3:30 PM - Interview with E5 (charge nurse) who confirmed the PRN pain medication documentation was inconsistent and there was no evidence that a post pain assessment was conducted for the above pain medication administrations.</p>	F 309			

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

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FORM APPROVED
OMB NO. 0938-0391

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F 309	Continued From page 28 These findings were reviewed with E1 and E2 on 11/10/15 at 11:40 AM.	F 309		
F 323 SS=D	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 observation it was determined that the facility failed to ensure that the resident environment is free of accident hazards in 3 (212, 214 and 221) out of 40 rooms. Findings include: Observations made during Stage 1 on 11/3, 11/4/15 [between 8:00AM-4:PM] and during the tour on 11/6/15 [between 11:00-11:50AM] revealed: -loose grab bars in the bathrooms of 212, 214 and 221 Findings were reviewed with E9 (Director of Support Services) on 11/9/15 at 9:10 AM. Findings were reviewed with E1 (NHA) and E2 (DON) on 11/10/15 at 11:40 AM.	F 323	F323 483.25(h) FREE OF ACCIDENT HAZARDS/ SUPERVISION/DEVICES A. The loose grab bars were repaired in each room identified. B. All other rooms were inspected and work requests were placed for any issues. C. An inspection check sheet will be developed for the housekeepers to use once a week to check for loose grab bars. An in-service will be conducted by the Director of Support Services with all housekeepers to prevent deficiency from happening again. D. The Housekeeping Team Leader will perform random inspections of rooms weekly for 4 weeks then monthly for 6 months or until 100% compliance is met for 3 consecutive months. Findings will be reported at the Quarterly Quality Improvement Committee Meeting to ensure that solutions are permanent (Attachment G).	11/09/15 11/09/15 12/10/15 12/30/15
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS	F 329		

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

PRINTED: 11/24/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085053	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/10/2015	
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F 329	<p>Continued From page 29</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 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: Based on record review and interview it was determined that the facility failed to ensure that each resident's drug regimen was free from unnecessary drugs for 1 (R74) out of 19 sampled residents. For R74 the AIMS test was not completed on admission and every 6 months while receiving an antipsychotic medication. Findings include:</p> <p>1. 3/10/15 - R74's admission to the facility on Zyprexa for the diagnosis of dementia with</p>	F 329	<p>F329 483.25(1) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>A. R74's AIMS test was completed during the survey and a physician's order was written to have the test completed every 6 months and documented on the TAR.</p> <p>B. All residents that have orders for psychotropic medication have had their charts reviewed to ensure that all Aims tests have been completed and scheduled on the TAR for every six months.</p> <p>C. All nursing staff has been in-serviced by the Staff Developer regarding the procedure for AIMS testing and documentation. All charge nurses will complete an initial AIMS test for all residents with physician's orders for psychotropic medications. The charge nurse will document the AIMS test schedule every six months in the TAR to ensure that all schedules will be completed. Random checks of AIMS test schedules will be completed by the DON/ADON weekly for 4 weeks and then monthly for 4 months or until 100% compliance is met for 3 consecutive months.</p> <p>D. A Quality Improvement audit tool has been developed and will be completed monthly by the DON/ADON reviewing all new admissions and then 10 residents per month for 4 months or until 100% compliance is met for 3 consecutive months and reported at the Quarterly Quality Improvement Committee Meeting by the DON/ADON to monitor the effectiveness of the systemic change and ensure that solutions are permanent (Attachment T).</p>	<p>11/04/15</p> <p>11/04/15</p> <p>11/09/15</p> <p>12/30/15</p>

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

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F 329	<p>Continued From page 30 behaviors.</p> <p>3/17/15 - Pharmacist documentation of the medication review requested nursing to complete the AIMS test.</p> <p>4/1/15 - Zyprexa discontinued and changed to Seroquel.</p> <p>6/10/15 - Pharmacist documentation of the medication review requested nursing to complete the AIMS test.</p> <p>6/16/15 and 9/16/15 - Quarterly MDS assessments documented the resident received an antipsychotic daily.</p> <p>10/10/15 - Pharmacist documentation of the medication review requested nursing to complete the AIMS test.</p> <p>Review of the resident's record revealed no documentation that an AIMS test was performed in March, June or October 2015.</p> <p>11/5/15 - Interview with E2 (DON) at 11:53 AM confirmed there was no completed AIMS test in R74's record. E5 [LPN] provided the surveyor with a completed AIMS dated 11/5/15.</p> <p>The facility failed to complete the AIMS test on admission and every 6 months for a resident admitted and receiving an antipsychotic medication.</p> <p>These findings were reviewed with E1 (NHA) and E2 on 11/10/15 at 11:40 AM.</p>	F 329		
F 356	483.30(e) POSTED NURSE STAFFING	F 356		

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

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F 356 SS=F	<p>Continued From page 31 INFORMATION</p> <p>The facility must post the following information on a daily basis:</p> <ul style="list-style-type: none"> o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: <ul style="list-style-type: none"> - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> o Clear and readable format. o In a prominent place readily accessible to residents and visitors. <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and interview, the facility failed to post the total number and the actual hours worked by licensed and unlicensed nursing staff directly responsible for resident care per shift</p>	F 356	<p>F356 483.30(e) POSTED NURSE STAFFING INFORMATION</p> <ul style="list-style-type: none"> A. A staffing sheet has been posted on the Skilled Unit in an area of accessibility to staff and visitors. 11/09/15 B. The sign reflects the facility name, date, and the total number of hours worked by the following categories: Registered Nurse, Licensed Practical Nurse and Certified Nursing Assistants (Attachment U). 11/09/15 C. All staff has been in-serviced by the Staff Developer regarding the sign and its contents. The charge nurse will check the staffing sheet at the start of each shift to ensure that all requirements have been met and to prevent the deficient practice from happening again. 11/19/15 D. A Quality Improvement audit will be completed by the DON/ADON to ensure that all requirements have been met and solutions are permanent. The findings will be reported at the Quarterly Quality Improvement Committee Meeting by the DON/ADON (Attachment V). 12/30/15

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

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F 356	Continued From page 32 on a daily basis in a prominent place readily accessible to residents and visitors. Findings include: Observations on 11/3/15 at 9 AM, 11/4/15 at 8:11 AM, 11/5/15 at 10:58 AM and 11/9/15 at 8:15 AM revealed a white board listing the date, first names of licensed and unlicensed staff each shift and the facility's daily census. Further observation revealed the absence of the total number and actual hours worked by direct care nursing staff. In an interview on 11/9/15 at 2:29 PM, E2 (DON) stated the total number and actual hours worked by direct care nursing staff on a daily basis were kept in a binder in the nurse's station. An observation on 11/9/15 at 2:30 PM revealed this information was recorded, however, it was not posted and accessible to residents and visitors. Findings were confirmed during an interview with E2 on 11/9/15 at 2:30 PM. Findings were reviewed with E1 (NHA) and E2 during the exit conference on 11/10/15 at 11:40 AM.	F 356			
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	F371 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY A. The dietary server was reassigned and educated regarding the infection control policy and procedure required in the food service area including the proper procedure for handling food items. The delivery person was notified that he must wear hair restraint when entering the kitchen. The cart was removed from in front of the handwashing sink.	11/03/15	

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

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085053	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/10/2015
NAME OF PROVIDER OR SUPPLIER CADBURY AT LEWES		STREET ADDRESS, CITY, STATE, ZIP CODE 17028 CADBURY CIRCLE LEWES, DE 19958		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	<p>Continued From page 33</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility failed to store, prepare and serve food under sanitary conditions in one out of two dining rooms. Findings include:</p> <p>1. 11/3/15 - Observation of plating and service of lunch between 12:05 PM - 12:50 PM in the assisted dining room by E15 (Dietary Server) whose hair net was worn in a manner that did not contain the hair on the front and both sides.</p> <p>12:25 PM - While wearing clean gloves E15 picked up a dirty dish from a resident table and scraped the food into the kitchen trashcan, opened the refrigerator and removed a plate with slices of hardboiled egg covered with plastic wrap.</p> <p>- Wearing the same contaminated gloves E15 removed the plastic wrap, used a fork to cut the eggs into smaller pieces, spooned out chicken onto the plate, added mixed vegetables, used knife and fork to cut up the vegetables into smaller pieces and served the plate with a gloved [contaminated] right thumb on top of the plate.</p> <p>- Picked up and carried a dirty bowl to the kitchen, removed gloves and put on new clean gloves without handwashing.</p> <p>- Carried another dirty dish to the kitchen and scraped leftover food into the trashcan.</p> <p>- Changed gloves without washing hands and used a spoon to plate mashed potato, mixed vegetable puree, chicken and gravy and served the plate at the table.</p>	F 371	<p>B. The sink is scheduled to be removed by the Maintenance Department. A hair net dispenser will be placed at each entrance to the kitchen area. The dietary server has been in-serviced by the Director of Dining on the proper procedure for infection control during food handling. All staff has been re-evaluated by the Director of Dining to ensure competency. All staff will be evaluated yearly by the Director of Dining to ensure that staff remains compliant in infection control practices/food handling. All vendors have been notified that any delivery person must wear a hair restraint when entering the kitchen. A hair net dispenser will be installed outside the entrance to the kitchen as well as a sign posted requiring use of a hair restraint.</p> <p>C. All dietary staff has been in-serviced and re-evaluated by the Director of Dining regarding the procedure for infection control when handling food and the importance of wearing a hair restraint when in food prep area. The staff was also educated regarding the importance of not blocking the sink with cart or equipment. Random checks of dietary staff will be completed for the Director of Dining weekly for 4 weeks and then monthly for 4 months or until 100% compliance is met for 3 consecutive months.</p> <p>D. A Quality Improvement tool will be completed monthly for 4 months or until 100% compliance is met for 3 consecutive months. Findings will be reported at the Quarterly Quality Improvement Committee Meeting by the Director of Dining to ensure that change is permanent (Attachment W).</p>	<p>01/08/15</p> <p>11/06/15</p> <p>12/30/15</p>

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

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F 371 Continued From page 34

F 371

12:34 PM - E15 touched a resident's shoulder using left gloved hand then returned to the kitchen and got out a clean plate, opened the refrigerator door and removed a plate with hardboiled eggs covered with plastic wrap, uncovered the eggs, cut up the eggs with a knife and fork, added mixed vegetables, chicken puree and served the plate with left contaminated gloved thumb touching the top of the plate.

12:40 PM - Wearing the same contaminated gloves, E15 plated a bowl of plain mashed potatoes and carried it to the table where E15 picked up a dirty plate and spoon, returned to the kitchen and scraped leftovers into the trash can.

12:55 PM - E15 touched a resident on the shoulder with a bare left hand, then returned to the kitchen, opened the refrigerator removed a metal container with chocolate pudding, got out a clean bowl with the contaminated left hand and plated the pudding and served the pudding.
- Picked up a dirty dish with her left hand from a dining table and returned to the kitchen and put the dish on the counter and was given another dirty dish which she held with both hands, then picked up a clean spoon to give to a CNA.

The facility failed to plate and serve a lunch meal in a sanitary manner.

These findings were reviewed with E1 (NHA) and E2 (DON) on 11/10/15 at 11:40 AM.

2. An observation was made on 11/3/15 on the initial kitchen tour from 10:55 to 11:08 AM of a delivery person, walking into the kitchen, through the preparation area, to the walk-ins, without

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 371	Continued From page 35 wearing a hair restraint. 3. An observation was made on 11/9/15 on a tour from 9:45 - 10:05 AM the handwashing sink was blocked by a tray cart, making it inaccessible. Findings were reviewed and confirmed by E7 (Dining Manager) and E10 (Director of Dining Services) on 11/9/15 at 10:05 AM. Findings were reviewed with E1 and E2 on 11/10/15 at 11:40 AM.	F 371			
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked,	F 431	F431 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS 1. A. All expired medications were removed from the medication cart. B. All medication carts were inspected for expired medications. The nursing staff will complete a daily medication cart check during their individual shifts. A weekly cart check will be completed of all medication carts and the medication room and all findings will be documented on the weekly medication check sheet (Attachment X). The pharmacy consultant will review the medication cart monthly to check for expired medications. C. All nursing staff has been in-serviced by the Staff Developer regarding the procedure for checking expired medications. The nursing staff will complete a daily medication cart check during their individual shifts to ensure that all medications are not expired. A weekly chart check on Wednesdays will be completed by the charge nurse to ensure that compliance is met with accuracy and consistency. D. A Quality Improvement tool will be completed monthly by the DON/ADON and all findings will be reported at the Quarterly Quality Improvement Committee Meeting by the DON/ADON to ensure solutions are permanent (Attachment Y).	11/06/15 11/25/15 11/19/15 12/30/15	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 431	Continued From page 38 permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1978 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and Interview it was determined that the facility failed to ensure a medication cart was free of a total of 81 expired medications. Findings include: On 11/6/15 at 2:20 PM the medication cart for North Hall was reviewed. An observation was made of two expired medication cards. Thirty-six tablets of Lorazepam 0.5mg expired on 10/30/15 and 45 tablets of Tramadol HCL 50mg expired on 10/31/15 and were still in the cart. At the time of the observation, E8 (LPN) and E5 (LPN) confirmed this finding. Findings were reviewed with E1 (NHA) and E2 (DON) 11/10/15 at 11:40 AM.	F 431	2. A. R74's post fall neurological assessment cannot be retroactively documented. All nursing behavior documentation cannot be retroactively completed. B. All residents with falls that have required neurological assessment have been reviewed to ensure that the required documentation is completed. All residents on psychotropic medications have been checked to ensure they have a behavior documentation sheet located in the MAR. A change of shift chart check has been initiated to ensure all behavior documentation in the MAR is complete (Attachment Z). C. All nursing staff has been in-serviced regarding the procedure for post fall neurological assessment and behavior sheet modification and the importance of completion of the required documentation to ensure consistency and accuracy. D. A Quality Improvement tool will be utilized weekly to review all SWIF review notes (fall notes) and behavior sheets to ensure that all necessary documentation has been completed and reported at the Quarterly Quality Improvement Committee Meeting to ensure solutions are permanent (Attachment AA).	11/09/15 11/10/15 11/19/15 12/30/15	
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities.	F 463	3. A. The CNA's behavior documentation and meal documentation cannot be retroactively documented. B. Resident behavior documentation in the flowsheets and meal percentage sheets have been reviewed to ensure that documentation is complete. The medical record clerk will review both sheets daily and report any missing signatures to the DON/designee.	11/09/15 11/30/15	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 463	Continued From page 37 This REQUIREMENT is not met as evidenced by: Based on observation it was determined that the facility failed to ensure all parts of the call bell system were functioning properly in 2 (220 and 225) out of 40 rooms. Findings include: Observations were made during Stage 1 (11/3/15-11/4/15 between 8:00 AM 4:30 PM) and on 11/6/15 from 11:00 - 11:50 AM of 2 (220 and 225 bathrooms having call light cords wrapped around the grab bar. A resident on the floor would have difficulty activating the wrapped call light cord in order to summon help. Findings were reviewed with E1 (NHA) and E2 (DON) 11/10/15 at 12:02 PM.	F 463	C. All staff has been in-serviced regarding the procedure for documenting behaviors and meal percentages to ensure accuracy. D. A Quality Improvement tool has been developed to monitor behavior sheets and meal percentage sheets monthly and report findings at the Quarterly Quality Improvement Committee Meeting to ensure solutions are permanent (Attachments BB and CC).	11/19/15 12/30/15
F 514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was	F 514	F463 483.70(f) RESIDENT CALL SYSTEM - ROOMS/ TOILET/BATH A. Call light cords were removed from the grab bars in both rooms and adjusted to be reachable from the floor. B. All other rooms were inspected to assure no other cords were wrapped around grab bars. C. An inspection check sheet will be developed for the housekeepers to use once a week to check for call bell issues. An in-service will be conducted by the Director of Support Services for all housekeepers. D. The Housekeeping Team Leader will perform random inspections of rooms to assure compliance. Findings will be reported at the Quarterly Quality Improvement Committee Meeting by the Director of Support Services (Attachment G).	11/09/15 11/09/15 12/10/15 12/30/15

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F 514	<p>Continued From page 38</p> <p>determined that the facility failed to maintain complete and accurate clinical records for 3 (R11, R74 and R8) out of 19 sampled residents. Findings include:</p> <p>1. Review of R11's clinical record revealed, R11 was scheduled to receive showers every Sunday and Wednesday on the 3-11 shift.</p> <p>Review of the TAR signed by the nurses documented when R11 received her scheduled showers was blank, absent of a documented signature on the following dates:</p> <p>-7/19/15, 7/26/15, and 7/29/15; -8/9/15, 8/16/15, and 8/30/15.</p> <p>Review of the CNA records that documented when the CNA completed R11's scheduled showers was blank, absent of a documented signature on the following dates:</p> <p>-6/24/15; -7/5/15, 7/12/15, 7/15/15, 7/19/15, 7/29/15; -8/9/15, 8/23/15, 8/26/15; -9/27/15, 9/30/15; -10/7/15.</p> <p>During an interview on 11/09/15 at 10:29 AM with E2 DON, it was confirmed that clinical record contained blanks in the sections designated for CNA and Nurse signature for completion of showers.</p> <p>These findings were reviewed with E1 (NHA) and E2 on 11/10/15 at 11:40 AM.</p> <p>Cross refer F309 example #3</p>	F 514	<p>F514 483.75(l)(1) RECORDS-COMPLETE/ACCURATE/ ACCESSIBLE</p> <p>A. R74's clinical records have been adjusted to indicate the diagnosis for the PRN Tylenol. R8's and R11's documentation cannot be retroactively documented. All residents' skin and hygiene has been checked by the DON/ADON to ensure that the residents were bathed within the timespan of review.</p> <p>B. R74's PRN pain medication cannot be retroactively documented for effectiveness of response to the PRN medication.</p> <p>C. The change of shift MAR check has been initiated for staff nurses to ensure the documentation is completed (Attachment M).</p> <p>D. A Quality Improvement audit will be completed weekly and reported at the Quarterly Quality Improvement Committee Meeting.</p>	<p>11/11/15</p> <p>11/11/15</p> <p>11/11/15</p> <p>12/30/15</p>

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F 514 Continued From page 39

F 514

2. Review of R74's clinical record revealed the following missing documentation:
- 3/10/15 - Physician order included PRN Tylenol for either headache/mild discomfort or fever. The reason was not recorded on the July through October MARs nor the monthly printed orders dated 10/30/15.
 - August, September and October, 2015 Narcotic Record for morphine: 13 doses not recorded, plus 1 instance the time was not written.
 - July through October, 2015 MAR's:
 - * PRN morphine administration not recorded on MAR twice
 - * Time of PRN morphine not recorded six (6) times and PRN laxative once
 - * Nurse initials for PRN morphine not recorded once
 - * Effect of a PRN laxative not recorded on the back of the MAR twice in October
 - July through October 2015 Pain Flow Sheet for PRN morphine:
 - * Missing 10 administrations
 - * Effect of PRN ativan recorded on pain flow sheet instead of the back of the MAR one time
 - Post Fall Assessment form:
 - * 3/24/15 and 5/23/15 - each missing one of the 4 assessments
 - Neuro Check for head injury form:
 - * 3/10/15 - missing 3 of the 4 assessment (8, 16 and 24 hours)
 - * 3/24/15 - missing 2 of the 4 assessments (16 and 24 hours)

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F 514	Continued From page 40 - July through October 2015 nurse behavior monitoring for Seroquel: * days - 12 shifts * evenings - 10 shifts - July through October 2015 nurse behavior monitoring for Klonopin: * days - 16 shifts * evenings - 13 shifts - August through October 2015 CNA Behavior Flowsheet for socially inappropriate: * days - 11 shifts * evenings - 19 shifts * nights - 13 shifts - August through October 2015 CNA behavior for physical abuse: * days - 12 shifts * evenings - 21 shifts * nights - 14 shifts - Meal percentage / liquid taken during meal: Breakfast - August 16, 17, 18, 27; October 28. Lunch - August 15, 16, 17, 18, 27; October 26, 27. Dinner - August 11, 15, 16, 19, 23, 24, 28, 29; September 18, 22, 24, 28, 29. - Bowel movement on CNA flowshee [these were absent documentation]: * days - August 11, 14, 15; October 25, 26, 28, 29, 30. * evenings - Aug 9, 11, 21, 26, 28; September 4, 16, 20, 25; October 2, 12; * nights - August 5, 8, 22, 29; October 11, 18. 11/9/15 - Interview with E2 between 10 AM - 10:20 AM confirmed times should be with initials	F 514
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F 514 Continued From page 41

F 514

on front of MAR. Expectation is that all information for PRN pain medications should be on Pain Flowsheet and not the back of the MAR. E2 stated that documentation had been identified as an issue, education had been conducted and chart audits were being completed. Some staff had been called into the office and were disciplined. E2 confirmed numerous missing documentation entries when shown copies of a variety of forms with missing or incorrect documentation highlighted. Review of facility records revealed a lack of consistent information on the MAR, pain flow sheet and signed out times on the narcotic records in comparison to the MARs for R74.

These findings were reviewed with E1 and E2 on 11/10/15 at 11:40 AM.

3. The following was reviewed in R8's clinical record:

9/2/15 MAR - 6 out of 13 (46%) medications were not signed off as given.

July 2015 - Behavioral/Intervention Monthly Flow Record was completed for night shift on 7/29, 7/30 and 7/31/15, despite the resident being in the hospital during this time period.

11/9/15 at 3:30 PM - Interview with E5 (LPN) confirmed the above documentation inconsistencies.

Findings were reviewed with E1 and E2 on 11/10/15 at 11:40 AM.

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**DELAWARE HEALTH
AND SOCIAL SERVICES**

Division of Long Term Care
Residents Protection

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

STATE SURVEY REPORT

NAME OF FACILITY: Cadbury at Lewis

DATE SURVEY COMPLETED: November 10, 2015

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
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<p>3201</p> <p>3201.1.0</p> <p>3201.1.2</p>	<p>The State Report incorporates by reference and also cites the findings specified in the Federal Report.</p> <p>An unannounced annual survey was conducted at this facility from November 3, 2015 through November 10, 2015. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 40. The Stage 2 sample totaled 19 residents.</p> <p>Regulations for Skilled and Intermediate Care Facilities</p> <p>Scope</p> <p>Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.</p> <p>This requirement is not met as evidenced by: Cross Refer to the CMS 2567-L survey completed November 10, 2015 F156, F167, F242, F244, F253, F278, F279, F280, F309, F323, F329, F356, F371, F431, F463 and F514.</p>	<p>F156 483.10(b)(5) – (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>A. The facility has posted a written description of resident's legal rights and the contact numbers of all pertinent State client advocacy groups including the Division of Long Term Care Resident Protection.</p> <p>B. All staff members and residents have been notified regarding the contents of the sign along with the location of the sign.</p> <p>C. All staff are in-serviced by the Staff Developer regarding resident rights and where contact information is posted. All residents are informed regarding their legal rights and exactly where the information is posted by the Staff Developer.</p> <p>D. A monthly Quality Improvement audit will be completed monthly for 4 months by the ADON to ensure that the postings remain intact. All findings will be reported at the Quarterly Quality Improvement Committee Meeting by the ADON to ensure solutions are permanent (Attachment A).</p>	<p>11/06/15</p> <p>11/19/15</p> <p>11/19/15</p> <p>12/30/15</p>
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Provider's Signature

Carol M. [Signature]

Title

Executive Director

Date

12/22/15



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<p>Title 16 Del.C., Chapter 11 Subchapter VII, § 1163(a)</p>	<p>Activities Staffing</p> <p>All residential health facilities licensed for 30 beds or more shall have a full-time activities director. Any activities director hired after July 1, 2001, shall be a certified therapeutic recreation specialist, a certified occupational therapy assistant, a certified music therapist, a certified art therapist, a certified drama therapist, a certified dance/movement therapist, a certified activities director, or a registered occupational therapist.</p> <p>This requirement is not met as evidenced by:</p> <p>Based on interview and review of facility documentation, it was determined that the facility failed to have a full time activities director as required by State law. Findings include:</p> <p>In an interview on 11/9/15 at 1:50 PM, E11 (DRS) stated that she currently holds the certification as the Activity Director for the skilled nursing care facility. E11 stated that in May 2015 she was promoted to Director of Resident Services for the entire community population, which included independent living, assisted living and skilled nursing care. E11 stated that she supervises unlicensed activity staff in the skilled nursing care facility.</p> <p>Review of the undated facility's description of essential duties and responsibilities of the Director of Resident Services included, but not limited to the following:</p> <ul style="list-style-type: none"> - "Attends nursing and assisted living care conferences on a regular basis, giving input that will contribute to residents' overall care...; - Attends Health Committee meetings monthly and reports as needed on community activities and addresses questions and 	<p>F167 483.10(g)(1) RIGHT TO SURVEY RESULTS – READILY ACCESSIBLE</p> <ul style="list-style-type: none"> A. Survey results have been posted in an area that is readily accessible to all residents and visitors. A notice has been posted in the lobby of the health care center regarding the location of the survey results. 11/06/15 B. All residents and staff have been informed of availability and location of survey results. 11/19/15 C. All staff will be in-serviced by the Staff Developer regarding survey results and location of survey information. The DON/designee will check the survey results with a monthly audit to ensure that survey results are posted correctly. 11/19/15 D. A Quality Improvement audit will be completed monthly for 4 months and will be reported at the Quarterly Quality Improvement Committee Meeting by the DON/designee to ensure solutions are permanent (Attachment B). 12/30/15 <p>F242 483.15(b) SELF-DETERMINATION – RIGHT TO MAKE CHOICES</p> <ul style="list-style-type: none"> A. A shower schedule was reviewed with R11's family and they have agreed to the shower schedule. 11/27/15 B. A focus review was completed on all current residents by the charge nurse to ensure that all personal hygiene has been implemented. All residents are interviewed upon admission by the charge nurse regarding their preference for a shower or bath. A nurse will verify that a shower or bath was completed and documented on the TAR on assigned days (Attachment C). This review and monitoring will be completed by the charge nurse/ADON. 11/19/15 	

Provider's Signature

Carl M. H. [Signature]

Title

Executive Director

Date

12/22/15



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STATE SURVEY REPORT

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Provider's Signature Cawp MHD Title Executive Director Date 12/22/15



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Provider's Signature

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Provider's Signature

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Title

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Date

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Provider's Signature Curt M. B.

Title Executive Director Date 12/22/15



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Provider's Signature

Carl M. [Signature]

Title

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Date

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STATE SURVEY REPORT

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DATE SURVEY COMPLETED: November 10, 2015

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Provider's Signature

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Title

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