

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

PRINTED: 08/02/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>085053</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/17/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>CADBURY AT LEWES</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>17028 CADBURY CIRCLE</b> <b>LEWES, DE 19958</b>	
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F 000	<p><b>INITIAL COMMENTS</b></p> <p>An unannounced complaint survey was conducted at this facility from June 14, 2016 through June 17, 2016. 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 thirty seven (37). The complaint sample totaled three (3) residents.</p> <p>Abbreviations used in this report are as follows:</p> <p>ED - Executive Director; DON - Director of Nursing; ADON - Assistant Director of Nursing; RN - Registered Nurse; LPN - Licensed Practical Nurse; CN - Charge Nurse; MD - Medical Director; CNA - Certified Nurse's Aide; NP - Nurse Practitioner; 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 assessment used in nursing homes);</p> <p>Acute renal failure - kidneys suddenly cannot remove waste products from the blood; Acute respiratory failure - fluid suddenly builds up</p>	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/15/2016

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 in the lungs reducing oxygen to the body; Abdominal aortic aneurysm - weakened, bulging area of the lower part of the major blood vessel supplying blood to the body; Afib (Atrial Fibrillation) - irregular heart rhythm that increases risk for blood clots; Anemia - reduced ability of red blood cells to carry oxygen to organs causing tiredness; Anxiety - feeling worry, nervous or restless; BM-bowel movement; CHF (Congestive Heart Failure) - heart cannot pump enough blood to meet the body's needs; Chronic kidney [renal] disease - progressive decline of kidney function; main causes include diabetes and high blood pressure; Comfort care - care that helps or soothes a person who is dying; Coumadin (warfarin) - medication to prevent blood clots; CT Scan - test that takes detailed picture inside the body; Cyanosis - a dusky, bluish color caused from lack of oxygen; Dehydration - a condition when the body has less than normal fluid; Diabetes Mellitus (DM) - disease with high levels of sugar in the blood; Diuretic - medicine to reduce water/excess fluid in the body; Dialysis-cleansing of the blood by artificial means when kidneys have failed; Edema - build-up of fluid causing swelling; e.g.-for example; Fahrenheit (F) - temperature scale; Fingerstick - obtain a drop of blood from finger to determine the level of glucose; Fluid overload - too much fluid in the blood; Hallucinations - something that seems real but does not really exist;	F 000		

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F 000	Continued From page 2 Hyperglycemia - high blood glucose/sugar; Hyperkalemia - high blood potassium; Hypoglycemia - low blood glucose/sugar; Hypoxia / Hypoxic - not enough oxygen reaching body tissues; Incentive spirometer - device to promote deep breathing to improve lung function; Infiltrate - lung air sacs filled with fluid; INR (International Normalized Ratio) - blood test to monitor effect of blood thinners; Insulin - injected medication to control blood sugar levels; Intravenous - given directly into the vein; Insulin - injected medication to control blood sugar levels; i.e.-that is; mL (milliliter) - metric measurement of liquid volume; Morphine - narcotic pain reliever; Multilobar - affecting several sections of the lungs; Myelodysplastic syndrome - blood related medical conditions with poor production of all blood cells; Nasal cannula - tubing with prongs delivering oxygen into the nose; NKHS (Nonketotic Hyperosmolar State) - complication from high glucose causing dehydration and renal failure, treat dehydration, high glucose and underlying cause (i.e., infection); OT-occupational therapy/therapist; Pneumonia - lung infection; Pulmonary edema - see CHF Pulmonary venous congestion - see CHF Pulse Oximetry [ox] - measures blood oxygen levels - desired range 94% to 100%; POS-physician order sheet; Sliding scale - dose of insulin based on glucose level;	F 000		

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F 000	Continued From page 3	F 000			
F 157 SS=D	<p>TIA - Transient ischemic attack (mimics a stroke); Transfusion dependent - needs blood transfusions as blood count drops; X-ray - picture taken of bones or organs.</p> <p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p>	F 157		7/29/16	

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F 157	Continued From page 4  This REQUIREMENT is not met as evidenced by: Based on record review, interview and review of other facility documentation it was determined that the facility failed to consult with the resident's physician for significant changes in the resident's glucose (sugar) and pulse ox readings for one (R1) out of 3 sampled residents. Findings include:  Facility standing order (last revised March 2011) included: - Diabetic Emergency Protocol for Hypoglycemia documented the statement to notify the physician immediately of blood sugar and intervention (after treating for low blood glucose). - Treatment for chest pain, shortness of breath, cyanosis involved beginning oxygen by nasal cannula and notify physician.  Cross Refer F309, Example 1 1. Review of R1's clinical record revealed:  May 2016 POS showed the resident did have an order to notify the physician when blood glucose reached specified high parameter.  5/29/16 (8:27 AM) nursing note - Documented treatment for low glucose of 52. There was no evidence in the nursing notes or faxes sent to the physician that E9 (Physician/MD) was notified immediately per the standing order.  Review of June 2016 fingersticks discovered a rising trend several days after the diabetes medication was stopped effective 6/1/16. - 6/3/16: am 245, pm 354 - 6/4/16: am 232, pm 405	F 157	This plan of correction has been prepared pursuant to the provisions of both Federal and State laws. Preparation and/or execution of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies.  1. R1 was discharged from the facility.  2. A focus review of all current residents has been completed by the DON/ADON to ensure that all changes in resident condition have been reviewed by the MD and have been addressed appropriately.  3. A process has been added by the Staff Developer to the existing EMR that is an enhanced step by step process for the nurse to follow when there is a change in resident's condition (Attachment A). A Vital Sign Alerting System, including blood sugar and pulse oximetry, has been added to our existing Change In Shift Monitoring System (Attachment B) as an additional alert to clinical staff to document alterations in any resident status. All nursing staff will be in-serviced within the next two weeks by the Staff Developer regarding the enhanced change in condition process and policy for alert charting. This includes the Vital Sign Alerting System, with the guidelines for alert charting with physician notification. The DON/Designee will review all nurses	

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F 157	<p>Continued From page 5</p> <ul style="list-style-type: none"> <li>- 6/5/16: am 266, pm 368</li> <li>- 6/6/16: am 432, pm 593</li> <li>- 6/7/16: am 350</li> </ul> <p>Review of June, 2016 faxes sent to E9 (Physician) and nursing notes found no evidence that E9 or E11 (NP) were informed of elevated glucose levels before dinner on June 3 (reading of 354) and June 6 (reading of 593).</p> <p>6/5/16 (9:54 PM) nursing note - Pulse oximetry (ox) was 81-82 percent, checked again within 1 minute then placed on 2 liters of oxygen by nasal cannula. Resident did not appear to be in any distress although R1 admitted to feeling a bit short of breath. Pulse ox 95 percent on oxygen. There was no evidence in the nursing notes or physician faxes that the standing order to notify the physician was followed when oxygen was initiated.</p> <p>During an interview with E8 (CN) on 6/16/15 at 9:30 AM when asked what glucose reading would prompt the nurse to contact the physician, E8 responded "over 350 unless otherwise ordered" by the doctor.</p> <p>During an interview with E3 (LPN) on 6/16/16 at 9:40 AM when asked about calling the physician for elevated glucose levels, E3 said when calling for high or low, it depends on the order. When asked if the glucose is high and there is no insulin coverage ordered, E3 would call the physician immediately.</p> <p>During an interview with E2 (DON) on 6/17/16 at 9:30 AM the lack of physician notification to the aforementioned high glucose readings was discussed. Reviewed the low pulse ox reading</p>	F 157	<p>notes with charting alerts and shift monitoring, as well as the change in condition process. This will be reviewed daily for one month and then weekly until 100% compliance is met.</p> <p>4. Quality improvement audits by the DON/Designee will be completed daily for one month and then weekly to ensure that all changes in resident's condition have been addressed. The weekly audit will continue until 100% compliance is met. The results of the audit will be reported at the quarterly Quality Improvement Committee meeting by the DON/Designee (Attachment C).</p>		

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F 157	Continued From page 6 on June 5 and that there was no evidence that the physician or NP was informed at the time of occurrence. At 10:58 AM E2 was not able to provide evidence that the low pulse ox on June 5 or the glucose levels June 3 (354) or June 6 (593) were ever relayed to the physician or NP at the time of occurrence. E2 said she will try to locate fax verifications about MD notification for these incidences. No additional information was provided by the facility to the surveyor at the time of exit.	F 157		
F 309 SS=G	These findings were reviewed with E1 (ED) and E2 on 6/17/16 at 1:30 PM. <b>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</b>  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 review, interview and review of other facility documentation it was determined that the facility failed to provide the necessary care and services for two (R1 and R2) out of 3 sampled residents. For R1 there was no evidence of ongoing assessment when the resident's condition was declining in the presence of fluctuating blood sugars. This was followed by discontinuation of oral medication for blood sugars followed by periods of rising blood sugar	F 309	This plan of correction has been prepared pursuant to the provisions of both Federal and State laws. Preparation and/or execution of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies.  1. Residents R1 and R2 have been	8/15/16

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F 309	<p>Continued From page 7</p> <p>levels. There was lack of evidence of timely response and physician intervention for R1 who experienced a decline in condition. For R2, there was no reassessment during the night shift following an episode of bloody urine. R2 was admitted to the hospital on 6/7/16 with acute renal failure with CHF. Findings include:</p> <p>Facility policy and procedure entitled Guidelines for Alert Charting and 24 hour Report (undated) included the following:</p> <p>* Procedure:</p> <p>-- Any nurse can initiate a resident to Alert Charting and begin documentation on the 24 hour report.</p> <p>-- Once resident has been placed on alert charting, nursing will continue to document until event has resolved. All follow up should be documented on the 24 hour report sheet.</p> <p>-- Each shift will document on chart and will initial the alert charting form.</p> <p>-- Once event no longer needs to be charted on, the event will be yellowed out as being discontinued on the form.</p> <p>* Guidelines for alert charting and 24 hour report included abnormal lab results, change in condition (i.e., vomiting, diarrhea, shortness of breath)</p> <p>* The charge nurse, DON/ADON will review all residents on the report and assess each resident to ensure that all appropriate measures have been taken.</p> <p>* Items on the 24 hour report will be communicated to the oncoming shift during change of shift report.</p> <p>1. Review of R1's paper and electronic clinical records revealed:</p>	F 309	<p>discharged from the facility.</p> <p>2. A focus review of all current residents was reviewed by the DON/Designee for any changes in condition including blood sugars greater than 350 or less than 70, diabetic medication, urine output or bloody urine, to ensure that all changes have been addressed and reviewed by the MD and appropriate treatments ordered.</p> <p>3. An additional process has been developed in the EMR system by the staff developer for any changes, as per alert charting policy, in the resident condition (see Attachment A). The process is a step by step procedure for the staff nurses to follow to manage resident clinical needs and meet compliance. All residents that have a change in condition will be placed on alert charting and documented on each shift regarding their change in condition. Any resident that has changes in diabetic medication will be placed on alert charting and monitored for seven days. Nurses will follow doctor's orders to discontinue diabetic medication and note so in the EMR if the blood sugar is outside the specified parameters. Any changes in resident's blood sugars above 350 or below 70 will be reported to the MD for corrective action. Any changes in residents urine output or blood in urine will be reported to the MD for corrective action. A change of shift monitoring system has been added that includes vital signs, finger sticks, and pulse oximetry and is reviewed each shift to ensure all changes have been addressed.</p>		

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F 309	<p>Continued From page 8</p> <p>5/18/16 - Admitted for rehabilitation with multiple diagnoses including diabetes, broken bone in low back and a blood disorder (Myelodysplastic Syndrome) requiring monthly blood transfusions for anemia.</p> <p>5/18/16 Physicians' orders included an oral pill once a day for diabetes and a fingerstick to check blood glucose (sugar) daily in the morning [before breakfast]. Standing orders included: - protocol for hypoglycemia if fingerstick glucose reading under 70. - treat chest pain, shortness of breath, cyanosis with oxygen by nasal cannula and notify physician.</p> <p>The American Diabetes Association (revised 6/17/15) suggested the following targets for most non-pregnant adults with diabetes. More or less stringent [strict] glucose goals may be appropriate for each individual: - Before meals: 80-131. - 1 to 2 hours after beginning of the meal: under 180. Reference: <a href="http://www.diabetes.org/living-with-diabetes/treatment-and-care/blood-glucose-control/checking-your-blood-glucose.html">http://www.diabetes.org/living-with-diabetes/treatment-and-care/blood-glucose-control/checking-your-blood-glucose.html</a></p> <p>5/20/16 - 5/30/16 - Review of fingersticks in the test section of the electronic record found daily glucose readings ranged from 85 - 212.</p> <p>5/25/16 - Admission MDS documented the resident was cognitively intact with no hallucinations or behaviors.</p> <p>5/29/16 (8:27 AM) Nursing Note - Called to room by CNA for R1 complaining of feeling hot. Head</p>	F 309	<p>Parameters have been set by the staff developer/DON in the EMR system for physician notification including blood pressure, pulse, finger sticks, pulse oximetry that will alert the nurse to changes in resident vitals and prompt them to follow the change in condition process (see Attachment A). A daily nursing skilled note has been developed in the EMR by the staff developer that guides the nurse through a head to toe assessment and documents specific changes in condition and other resident concerns (Attachment E). A daily task checklist has been developed by the DON to assist the charge nurse in monitoring compliance regarding changes in resident condition including changes in resident's vital sign parameters, fluctuating blood sugars, and changes in urine output including hematuria (Attachment F). The DON/Designee will review all documentation regarding changes in resident condition daily, to ensure 100% compliance is met daily for one month and then weekly or until 100% compliance is met. All staff will be in serviced by the staff developer regarding the change in condition process, the parameters for alerts in vitals and in the skilled nursing note documentation, as well as the charge nurse daily task list.</p> <p>4. A quality improvement audit will be completed weekly for one month and then monthly on all processes for change in resident's condition by the ADON to ensure 100% compliance is met. All findings will be reported at the quarterly</p>	

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F 309	<p>Continued From page 9</p> <p>felt hot to the touch but rest of skin cool and clammy. No fever. Fingerstick was 52. Orange juice given along with a fig bar. On recheck fingerstick now 60 and resident stated felt fine now. Resident did finish 8 oz of juice. Day nurse will recheck and monitor. Glucose reading documented at 10:57 AM by the day nurse was 88.</p> <p>5/30/16 Physician Progress Note by E9 (Physician/MD) - "... some trouble breathing that comes and goes, use incentive spirometer every hour while awake.....low blood sugar, discontinue [name of oral diabetic medication] (85, 88, 96, 161) and check fingerstick twice a day" [before breakfast and dinner].</p> <p>5/30/16 Physicians Orders included entry to discontinue the oral diabetes medication due to low blood sugar of 44. [It is unclear where the 44 came from since nursing notes recorded a glucose of 52 on 5/29/16 at 8:27 AM.] It is also unclear why the diabetes medication was discontinued after only one episode of low blood sugar as documented by pre-breakfast finger sticks.</p> <p>Review of June 2016 fingersticks discovered a rising trend several days after the diabetes medication was stopped on 6/1/16. (AM fingerstick taken before breakfast and PM fingerstick taken before dinner.)</p> <ul style="list-style-type: none"> <li>- 6/3/16: AM 245, PM 354</li> <li>- 6/4/16: AM 232, After dinner 405, 8:12 PM 488</li> <li>- 6/5/16: AM 266, PM 368, 9:15 PM 448</li> <li>- 6/6/16: AM 432, PM 593</li> <li>- 6/7/16: AM 350</li> </ul>	F 309	Quality Improvement Committee meeting by the ADON (Attachment G).	

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F 309	<p>Continued From page 10</p> <p>6/3/16 - Review of June, 2016 faxes sent to the E9 and nursing notes found no evidence that E9 or E11 (NP) were informed of rising glucose levels on June 3.</p> <p>6/4/16 (8:46 PM) nursing note - Last 5 results (taken twice daily) had been running high. Tonight 405 after dinner and at 8:12 PM was 488. Physician paged [E9].</p> <p>6/4/16 (9:40 PM) nursing note - E9 gave a one-time order for 4 units of regular insulin which was given. [There was no evidence in the record of fingerstick re-assessment after the insulin administration to determine effectiveness or the need for additional treatment.]</p> <p>6/5/16 (9:54 PM) nursing note - Pulse oximetry (ox) showing oxygen saturation of blood was 81-82 percent, checked again within 1 minute then placed on 2 liters of oxygen by nasal cannula. Resident did not appear to be in any distress although R1 admitted to feeling a bit short of breath. Pulse ox 95 percent on oxygen. [There was no evidence in the nursing notes or physician faxes that the standing order to notify the physician after the application of oxygen was followed.]</p> <p>According to the Mayo Clinic normal pulse oximetry readings usually range from 95 to 100 percent. Values under 90 percent are considered low. <a href="http://www.mayoclinic.org/symptoms/hypoxemia/basics/definition/SYM-20050930">http://www.mayoclinic.org/symptoms/hypoxemia/basics/definition/SYM-20050930</a></p> <p>6/5/16 (11:45 PM) nursing note - Glucose rechecked at 9:15 PM and was 448. E9 notified and ordered to restart the oral diabetes</p>	F 309		

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F 309	<p>Continued From page 11 medication the next morning. [No order to address the current high glucose level of 448.]</p> <p>6/6/16 NP Progress Note by E11 [NP] - Seen for shortness of breath with low pulse ox and placed on oxygen. Chest x-ray and blood count to be done immediately. For transfusion Wednesday [6/8/16] for chronic blood disorder causing anemia. Fluid pill ordered as a one-time dose for shortness of breath and edema from volume overload.</p> <p>6/6/16 (11:01 AM) late nursing note written 6/7/16 (11:06 AM) - Pre-breakfast fingerstick 432, resident pale and weak. E11 in to see resident and ordered a one time dose of a fluid pill, a complete blood count test, chest x-ray and vital signs every shift. [No order to address the current high glucose level of 432.]</p> <p>6/6/16 (fax dated 4:12 PM) - Chest x-ray showed pulmonary venous congestion (CHF) and the possibility of infiltrate (pneumonia) in the left lower lung field.</p> <p>6/6/16 (untimed) late nursing note written 6/7/16 at 2:53 PM - E9 notified of glucose of 577. [Glucose result in the test section of the electronic record was 593.] E9 informed of orders written by E11 [one-time fluid pill, blood test, chest x-ray, vital signs]. [No order to address the current high glucose level of 577 - 593.]</p> <p>6/7/16 (11:01 AM) nursing note stated Received in bed this morning, trying to climb out of bed, hallucinating, pulse ox 82 percent on 2 liters of oxygen, pulse ox 90 percent when oxygen increased to 3 liters. Looks pale, very weak. Fingerstick (before breakfast) glucose read HI</p>	F 309			

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F 309	<p>Continued From page 12 (larger number than glucose meter can determine, often 600). Spouse called and informed of change of condition. E9 called and ordered 6 units insulin now as well as fingerstick glucose before meals and bedtime with sliding scale insulin. Fluid pill ordered daily. All morning meds given. Repeated glucose (before lunch) still HI, re-notified E9 by fax.</p> <p>6/7/16 (11:24 AM) fax transmittal to E9 - "high" glucose at 7:30 AM and resident received 6 units of insulin. At 11:30 AM glucose still "high". Continues with hallucinations and has left lung sounds indicating fluid in the lung. Pulse ox 93 percent on 2.5 liters of oxygen. No fever. The electronic signature by E9 on the fax was timed at 2:03 PM. Fax sent to facility at 3:35 PM and included the notation "was discussed with [first name of E4 (ADON)]."</p> <p>6/7/16 (11:43 AM) nursing note - Glucose continued with HIGH reading, hallucinations continue. R1 with pale color and weakness. Resident and spouse request to be seen at emergency department for evaluation and treatment. E9 notified.</p> <p>6/7/16 (11:41 PM) nursing note - Resident admitted to hospital with altered mental status and bacterial pneumonia.</p> <p>During an interview with E8 (CN) on 6/16/15 at 9:30 AM E8 demonstrated how to locate times that notes were written and where to find fingersticks in the electronic record. When asked what glucose reading would prompt the nurse to contact the physician, E8 responded "over 350 unless otherwise ordered" by the doctor. When asked what happens if the doctor does not</p>	F 309		

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F 309	<p>Continued From page 13</p> <p>respond to the call or fax, E8 said if it is a Monday we call the NP. E8 added that staff call the office since the facility does not have E9's cell number. If the doctor does not respond, we keep calling. Depending on resident condition, we'll call 911. E8 added that "he's the only doc [doctor] we have." E9 is the primary physician for all residents and is the Medical Director as well.</p> <p>During an interview with E3 (LPN) on 6/16/16 at 9:40 AM when asked about calling the physician for elevated glucose levels, E3 said when calling for high or low, it depends on the order. When asked what the response would be if the glucose is high and there is no insulin coverage ordered, E3 would call the physician immediately.</p> <p>During an interview with E2 (DON) on 6/16/16 at 9:55 AM when the surveyor asked for the policy about physician notification and/or chain of command, E2 confirmed the facility does not have a policy. E2 stated if the doctor does not call back, E2 might call the NP in his office. Surveyor requested policy and procedure for hypo / hyperglycemia as well as physician orders.</p> <p>During an interview with E2 on 6/16/16 at 10:37 AM the surveyor was given a copy of the facility standing orders which included bowel and hypoglycemia protocols along with several treatments. E2 stated the facility does not have anything (policy or protocol) for hyperglycemia. Policy of handling admission orders was provided to the surveyor. When discussing the lack of times on handwritten physician orders, E2 confirmed that "had been a problem" but not when orders are written directly in the computer.</p> <p>During an interview with E2 on 6/16/16 at 12:52</p>	F 309		

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F 309	<p>Continued From page 14</p> <p>PM to determine how to find out if alert charting was activated on a resident, E2 stated it is not in the chart, but on the 24 hour report. The surveyor requested to see the 24 hour reports from the past 2 weeks.</p> <p>Review of the alert charting forms revealed R1 was not included between 6/3/16 and 6/6/16 during which time the resident's glucose was elevated, pulse ox was low and shortness of breath increased.</p> <p>Review of May and June 2016 physician orders and treatments in the electronic record revealed the incentive spirometer was ordered 5/30/16 and was visible under treatment orders. However there was no evidence in the treatment section or nursing notes during this time frame that this treatment was ever implemented.</p> <p>Findings from interviews with E2 on 6/17/16 between 9:30 AM and 10:58 AM:</p> <ul style="list-style-type: none"> <li>- Incentive spirometer should be documented in the treatment section. E2 confirmed there was no proof that the incentive spirometer treatment was performed.</li> <li>- High glucoses on June 3 PM reading of 354; June 6 AM reading of 432 and PM reading of 593 without evidence that the NP or physician were informed. NP note acknowledged the 432 glucose which was not treated.</li> <li>- Low pulse ox reading on June 5 (two days before R1 was sent to the hospital) without evidence that the physician or NP was informed at the time of occurrence. E2 was not able to provide evidence that the low pulse ox on June 5 or the glucose of 593 on June 6 was ever relayed to the physician or NP at the time of occurrence.</li> <li>- E2 said she will try to locate fax verifications</li> </ul>	F 309		

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F 309	<p>Continued From page 15 about MD notification for the above incidences.</p> <p>6/22/16 - Review of hospital records showed: - R1 was seen in the emergency department 6/7/16 at 12:36 PM. Fingerstick at 12:37 PM was 511. Chest x-ray and chest CT scan revealed pulmonary edema (CHF), extensive lung abnormality suggesting significant pneumonia and partial collapse of both lungs. - Emergency department history and physical documented diagnoses including acute respiratory failure from multilobar pneumonia versus CHF, acute renal failure and NKHS. - Treatment included intravenous hydration for dehydration from high glucose, antibiotics for pneumonia, diuretic for pulmonary edema and continuous insulin infusion to bring glucose levels down within normal range. - On the morning of 6/8/16 comfort care measures were started including morphine infusion for shortness of breath and other medications for nausea, excess saliva and anxiety.</p> <p>The facility failed to follow the plan of care and: - Consistently respond to rising glucose fingersticks over four days and reassess glucose after a one-time dose of insulin was administered. R1 developed NKHS leading to acute renal failure from dehydration due to elevated glucose levels. Acute renal failure leads to fluid build up in the body and lungs (CHF). <a href="http://www.diabetes.org/living-with-diabetes/complications/hyperosmolar-hyperglycemic.html">http://www.diabetes.org/living-with-diabetes/complications/hyperosmolar-hyperglycemic.html</a> -Implement the order for incentive spirometer every 1 hour while awake for seven days after ordered by the physician. R1 had both lungs that were partially collapsed and developed</p>	F 309		

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F 309	<p>Continued From page 16</p> <p>pneumonia.</p> <ul style="list-style-type: none"> <li>- Follow the standing order to notify the physician after oxygen was initiated for shortness of breath. R1 developed CHF, pneumonia and partial collapse of both lungs leading to acute respiratory failure.</li> <li>- Initiate alert charting when the resident's condition changed to assure follow-up on R1's status leading to a delay in treatment.</li> </ul> <p>These findings were reviewed with E1 (ED) and E2 on 6/17/16 at 1:30 PM.</p> <p>2. 2011 Guidelines on oral anticoagulation with Warfarin (Coumadin) - fourth edition by the Agency for Healthcare Research and Quality include the INR goal of 2.5 for persons with afib. <a href="http://www.guideline.gov/content.aspx?id=34978">http://www.guideline.gov/content.aspx?id=34978</a></p> <p>Review of R2's clinical record revealed:</p> <p>5/26/16 - Admitted for rehabilitation with numerous diagnoses including chronic kidney disease, diabetes, afib (on Coumadin), recent abdominal aortic aneurysm repair, and history of multiple heart attacks.</p> <p>6/1/16 (3:23 PM) care plan meeting note - R2, spouse and daughter in attendance. Needs supervision for transfers and toileting. R2 loses balance and is unable to self correct at this point... Continues on Coumadin.</p> <p>6/5/16 (5:42 AM) nursing note - Had stomach ache early in the shift [night shift] and then stomach was upset. R2 stated had a bowel movement today. Antacid effective to settle</p>	F 309		

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F 309	<p>Continued From page 17</p> <p>stomach. A few hours later R2 had some dry heaves, basin and ginger ale given, no vomiting occurred. Fell back asleep.</p> <p>Review of CNA documentation of bowel movements found the resident had a BM on May 27, 28, 31, June 1, 3 and 6.</p> <p>6/6/16 NP Progress note - Complained of constipation and mid abdominal pain. Check abdominal x-ray.</p> <p>Review of INR tracking for routine Coumadin revealed the following INR results and medication adjustments:</p> <ul style="list-style-type: none"> <li>- 5/26/16: 1.36, dose remained 5 mg</li> <li>- 5/31/16: 1.59, dose increased to 6 mg</li> <li>- 6/2/16: 2.5, dose remained 6 mg</li> <li>- 6/6/16: 4.39, dose on hold recheck INR 6/9/16</li> </ul> <p>6/7/16 (12:57 AM) nursing note - episode of bloody urine (hematuria) this evening [6/6/16 on evening 3:00 PM - 11:00 PM shift]. INR results elevated and Coumadin placed on hold (until a blood test is done 6/9/16). Abdominal x-ray showed normal gas pattern, no abnormalities. R2 denied pain after thorough assessment. Bowel sounds in all 4 quadrants, belly soft with mild distention noted. Encouraged resident to void. Oxygen in place upon assessment and pulse ox 93 percent. Resident continued to deny pain remainder of shift.</p> <p>6/7/16 at 1:07 AM - Family expressed concerns regarding resident's bloody urine at beginning of evening shift on 6/6/16 and felt R2 was not doing as well as he had been. Called physician who spoke with R2's son by telephone. Abdominal x-ray results (no abnormality) provided to family.</p>	F 309		

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F 309	<p>Continued From page 18</p> <p>R2 complained of being very tired.</p> <p>6/7/16 (11:22 AM) fax transmittal to E9 - Family states resident hasn't urinated since yesterday. He had bloody urine yesterday. Abdominal x-ray came back negative. Bladder assessment by the nurse was normal (indicating the resident was not retaining urine in the bladder). Reply fax at 3:35 PM included notation to encourage oral fluids, complete blood tests if not done within the last week (electronically signed by E9 6/7/16 at 2:03 PM).</p> <p>6/7/16 (2:17 PM) nursing note - R2's daughter and granddaughter informed nursing that the resident stated he had not urinated since 5:00 PM on 6/6/16 when it was bloody. Family was advised that abdominal x-ray was negative and R2 did not have a fever. Assessment found abdomen was not distended, denied pain in the area over kidneys or feeling of pressure in the bladder. Bowel sounds present and hypoactive. Fluids were encouraged and taken well. E9 [MD] had been advised by the charge nurse on this shift of the resident's condition.</p> <p>6/7/16 (2:27 PM) nursing note - E9 made aware of bloody urine from previous shift. Family reported at 10:00 AM that the resident had not urinated since last night. Medication nurse assessed the resident's bladder, R2 denied pain or pressure upon palpation, denied flank pain, bowel sounds positive and bladder was non-palpable. E8 [CN] was called at 11:02 AM and faxed at 11:24 AM. MD was called again at 1:01 PM and 1:48 PM. MD responded [at 2:03 PM per fax] and gave no new orders, but notified the nurse he would be in tonight to see the resident. Resident and wife informed.</p>	F 309			

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F 309	Continued From page 19  6/7/16 (3:20 PM) nursing note - Orders had been given by E9 for STAT blood tests and straight catheterization. If more than 350 mL in the bladder to leave catheter in place. Wife was notified of the orders and informed the nurse that the son spoke with the physician who performed the abdominal aortic aneurysm repair 5/20/16 and that doctor wanted R2 taken to the emergency department right now. The resident, who was his own responsible party, was asked if he would like to be seen at the emergency department and responded yes. R2's son was informed the facility would get the paperwork ready. While printing the papers the nurse saw the family wheeling R2 to the elevator in a wheelchair. The family was asked to wait for the paperwork that the hospital would need but the son stated "I'm not waiting, I'm getting my father out of here, he is having trouble breathing." The nurse noted no oxygen tank was hooked up to R2's oxygen tubing and asked the family to "let us help". As the elevator door was closing the son stated they were calling 911. E9 made aware.  6/7/16 (11:39 PM) nursing note - Resident was admitted to the local hospital with renal failure, hyperkalemia and CHF.  During an interview with E6 (RN) on 6/14/16 at 3:05 PM E6 stated "we don't have a bladder scan." [Bladder scan is a piece of equipment that can determine the amount of urine in the bladder without the need to insert a catheter.] <a href="http://www.nursingtimes.net/nursing-practice/clinical-zones/continence/using-bladder-ultrasound-to-detect-urinary-retention-in-patients/5001853.article">http://www.nursingtimes.net/nursing-practice/clinical-zones/continence/using-bladder-ultrasound-to-detect-urinary-retention-in-patients/5001853.article</a>	F 309			

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F 309	<p>Continued From page 20</p> <p>During an interview with E2 (DON) on 6/16/16 at 9:55 AM E2 confirmed the facility did not have a policy for notification of the physician or a process for when the physician does not respond in a timely manner.</p> <p>During an interview with E2 on 6/16/16 at 12:52 PM to determine how to find out if alert charting was activated on a resident, E2 stated it is not in the chart, but on the 24 hour report. The surveyor requested to see the 24 hour reports from the past 2 weeks.</p> <p>Review of the alert charting forms revealed R2 was not included on 6/6/16 after the resident had bloody urine.</p> <p>During an interview with E3 (LPN) on 6/16/16 at 1:20 PM the nurse showed the surveyor where/how urine color is documented on the Skilled Note Clinical Note screen in the computer. The urine color question was located in the middle of the screen while all other urine related questions were positioned on the left side of the screen. The question allowed for selection of the following urine colors: amber, orange, straw, tea and bloody. E3 stated that day shift documents on residents in even rooms and evening shift documents on residents in odd rooms. The overnight shift does not document but should write a note if something unusual happens. When discussing E9's response when the facility calls about resident concerns, E3 indicated that the physician often does not respond in a timely manner and often E9's response is "to monitor" the resident.</p> <p>During an interview with E9 on 6/16/16 at 2:36 PM when asked about the expectation for</p>	F 309			

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F 309	Continued From page 21 response when the facility calls, E9 stated "1.5 hours." The physician proceeded to say that if he doesn't respond after the first call, the facility should call a second time (to the office during the day). If a third call is needed the facility should go through the answering service to have him paged. E9 indicated the delay in response may be due to a dead cell phone battery or that the phone being locked in the car. According to the physician contacting by fax or phone had been working well.  During an interview with E2 on 6/17/16 at 9:40 AM the surveyor discussed the inability to locate a nursing assessment after the evening shift when the bloody urine occurred. Later at 10:58 AM E2 brought a copy of documentation from hematuria episode by evening shift however did not address the lack of reassessment by night shift. There was no evidence in the record that the resident's urine/bladder status was assessed on night shift following the episode of hematuria.  6/17/16 review of hospital records discovered the resident arrived at the emergency department on 6/7/16 at 3:25 PM by private vehicle with acute renal failure and CHF. Dialysis started. INR 4.81.	F 309			
F 389 SS=D	483.40(d) PHYSICIAN FOR EMERGENCY CARE, AVAILABLE 24HR  The facility must provide or arrange for the provision of physician services 24 hours a day, in case of an emergency.	F 389		7/29/16	

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F 389	<p>Continued From page 22</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, interview and review of other facility documentation it was determined that the physician failed to respond in a timely manner when called for a change of condition of two (R1 and R2) out of 3 sampled residents. Both residents were transported to the emergency department for evaluation and treatment and were admitted to the hospital for continued management. Findings include:</p> <p>Review of the facility policy and procedure entitled Medical Staff Guidelines (undated) discovered duties of the skilled care physician included to respond by phone or in person in the case of an emergency with a resident. [The policy did not provide a time frame for response nor did it include the utilization of the fax machine as a means to respond.]</p> <p>Cross Refer F309, Example 1</p> <p>1. Review of R1's clinical record revealed:</p> <p>6/7/16 (11:24 AM) fax transmittal about R1 to E9 [MD] - "high" glucose at 7:30 AM and R1 received 6 units of insulin. At 11:30 AM glucose still "high". Continues with hallucinations and has left lung crackles [indicating fluid in the lung]. Pulse ox 93 percent on 2.5 liters of oxygen. No fever. The electronic signature by E9 on the fax was timed at 2:03 PM, more than 2.5 hours after the fax was sent. Fax returned to facility at 3:35 PM (now 4 hours from when the fax was sent) and included the notation "was discussed with [first name of E4 (ADON)]."</p> <p>During an interview with E8 (CN) on 6/16/15 at</p>	F 389	<p>This plan of correction has been prepared pursuant to the provisions of both Federal and State laws. Preparation and/or execution of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies.</p> <ol style="list-style-type: none"> <li>Residents R1 and R2 have been discharged from the facility.</li> <li>A focus review of all current residents was completed to ensure that any changes in condition have been followed up by the MD.</li> <li>A revised policy and procedure has been completed by the DON for physician notification (Attachment H). The DON has posted a sign with the appropriate phone numbers of the MD and the NP (Attachment I) to increase accessibility. The MD is to be notified by phone at his office during business hours (8am -4 pm) and the answering service after business hours. All staff will be in-serviced by the Staff Developer regarding the revised policy and procedure within the next two weeks. The DON/Designee will review all alert charting/changes in resident condition every 24 hours x 1 month and then weekly until 100% compliance is met.</li> <li>A quality improvement audit by the DON/Designee will be completed daily for</li> </ol>	

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F 389	<p>Continued From page 23</p> <p>9:30 AM when asked what happens if the doctor does not respond to the call or fax, E8 said if it is a Monday we call the NP. E8 added that staff call the office since the facility does not have E9's cell number. If the doctor does not respond, we keep calling. Depending on the resident's condition, we'll call 911. E8 added that "he's [E9] the only doc [doctor] we have." E9 is the primary physician for all residents and is the Medical Director as well.</p> <p>During an interview with E2 (DON) on 6/16/16 at 9:55 AM E2 confirmed the facility did not have a policy for notification of physician or the or process if the physician did not respond timely.</p> <p>During an interview with E3 (LPN) on 6/16/16 at 1:20 PM the nurse indicated that E9 often does not respond in a timely manner and frequently E9's response is "to monitor" the resident.</p> <p>During an interview with E9 on 6/16/16 at 2:36 PM when asked about the expectation for response when the facility calls, E9 stated "1.5 hours." The physician proceeded to say that if he doesn't respond after the first call, the facility should call a second time (to the office during the day). If a third call is needed the facility should go through the answering service to have him paged. E9 indicated the delay in response may be due to a dead cell phone battery or that the phone being locked in the car. According to the physician the process of contacting by fax or phone had been working well.</p> <p>The physician failed to respond in a timely manner to a fax from the facility regarding the change of condition for R1. Response time by E9 was 4 hours.</p>	F 389	<p>one month and then weekly for 3 months or until 100% compliance is met (Attachment J). A review of all current residents has been completed by the MD to ensure that all changes in resident's condition have been met. The results of the audit will be reported at the quarterly Quality Improvement Committee meeting by the DON.</p> <p>Attachment H</p> <p>Physician Notification</p> <p>Purpose: To ensure that the physician is notified regarding all changes in the resident's condition, so that appropriate measures can be put into place to maintain quality of patient care.</p> <p>Procedure:</p> <ol style="list-style-type: none"> <li>1. The Nurse must notify the Physician via phone regarding any changes in resident's condition. (See Policy for guidelines for alert charting).</li> <li>2. The physician must be called at the office during business hours.</li> <li>3. The answering service may be called after hours; Numbers are available at the Nurses station.</li> <li>4. The Nurse needs to place a second call to the Physician if he does not return your call within a half and hour.</li> <li>5. The Nurse needs to call the Nurse Practitioner if the physician is not available.</li> <li>6. The Nurse will place the resident on Alert Charting for documentation. (see Alert Charting policy)</li> </ol>	

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F 389	Continued From page 24  These findings were reviewed with E1 (ED) and E2 on 6/17/16 at 1:30 PM.  Cross Refer F309, Example 2 2. Review of R2's clinical record revealed:  R2's 6/7/16 (2:27 PM) nursing note - E9 (MD) made aware of bloody urine from previous shift. Family reported at 10:00 AM that the resident had not urinated since last night. Medication nurse assessed the resident's bladder, R2 denied pain or pressure upon palpation, denied flank pain, bowel sounds positive and bladder was non-palpable. E8 (CN) was called at 11:02 AM and faxed at 11:24 AM. MD was called again at 1:01 PM and 1:48 PM. E9 responded at 2:03 PM per fax (over 3 hours after the first telephone call), gave no new orders, but notified the nurse he would be in tonight to see R2.  6/7/16 (3:20 PM) nursing note - Orders given by E9 for STAT blood tests and straight catheterization. If more than 350 mL in the bladder to leave catheter in place. Wife was notified of the orders and informed the nurse the son spoke with the physician who performed the abdominal aortic aneurysm repair 5/20/16 and that doctor wanted R2 taken to the emergency department right now. The resident, who was his own responsible party, was asked if he would like to be seen at the emergency department and responded yes. R2's son was informed the facility would get the paperwork ready. While printing the papers the nurse saw the family wheeling R2 to the elevator in a wheelchair. The family was asked to wait for the paperwork that the hospital would need but the son stated "I'm not waiting.	F 389	7. Do not fax changes in patient's condition to the office. Faxes sent to the doctor are for information purposes only and do not require an urgent response.		

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F 389	<p>Continued From page 25</p> <p>I'm getting my father out of here. He is having trouble breathing." The nurse noted no oxygen tank was hooked up to R2's oxygen tubing and asked the family to "let us help". As the elevator door was closing the son stated they were calling 911. E9 made aware.</p> <p>During an interview with E2 (DON) on 6/16/16 at 9:55 AM when the surveyor asked for the policy about physician notification and/or chain of command, E2 confirmed the facility does not have a policy. E2 stated if the doctor does not call back, E2 might call the NP in his office.</p> <p>During an interview with E9 on 6/16/16 at 2:36 PM when asked about the expectation for response when the facility calls, E9 stated "1.5 hours." The physician proceeded to say that if he doesn't respond after the first call, the facility should call a second time (to the office during the day). If a third call is needed the facility should go through the answering service to have him paged. E9 indicated the delay in response may be due to a dead cell phone battery or that the phone being locked in the car. According to the physician the process of contacting by fax or phone has been working well.</p> <p>6/17/16 review of hospital records discovered the resident arrived at the emergency department on 6/7/16 at 3:25 PM by private vehicle with acute renal failure and CHF. Dialysis started.</p> <p>The physician failed to respond in a timely manner to calls from the facility regarding the change of condition for R2. Response time for R2 was 3 hours.</p> <p>These findings were reviewed with E1 (ED) and</p>	F 389			

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F 389	Continued From page 26 E2 on 6/17/16 at 1:30 PM.	F 389		
F 501 SS=D	<b>483.75(i) RESPONSIBILITIES OF MEDICAL DIRECTOR</b>  The facility must designate a physician to serve as medical director.  The medical director is responsible for implementation of resident care policies; and the coordination of medical care in the facility.  This REQUIREMENT is not met as evidenced by: Based on record review, interview and review of other facility documentation it was determined that the medical director failed to implement policies and procedures and failed to respond in a timely manner when called for a change of condition for two (R1 and R2) out of 3 sampled residents. Findings include:  Review of the facility policy and procedure entitled Medical Staff Guidelines (undated) revealed duties of the skilled care physician included to respond by phone or in person in the case of an emergency with a resident. [The policy did not provide a time frame for response nor did it include the utilization of the fax machine as a means to contact/respond.]  Cross Refer F309, F389, F514, example 2.  1. Review of R1's clinical record revealed:  6/7/16 (11:24 AM) fax transmittal about R1 to E9 [MD] - "high" glucose at 7:30 AM and R1 received 6 units of insulin. At 11:30 AM glucose still "high".	F 501	This plan of correction has been prepared pursuant to the provisions of both Federal and State laws. Preparation and/or execution of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies.  1. Residents R1 and R2 have been discharged from the facility.  2. A focus review of all current residents has been completed by the DON/ADON to ensure changes in condition have been reviewed by the MD.  3. A revised policy and procedure has been implemented to supplement the existing procedure for physician notification to include contact information for a second practitioner. This policy has been reviewed by the MD (Attachment H). A weekly meeting with the DON/ADON	7/15/16

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F 501	<p>Continued From page 27</p> <p>Continues with hallucinations and has left lung crackles [indicating fluid in the lung]. Pulse ox 93 percent on 2.5 liters of oxygen. No fever. The electronic signature by E9 on the fax was timed at 2:03 PM, more than 2.5 hours after the fax was sent. Fax returned to facility at 3:35 PM (now 4 hours from when the fax was sent) and included the notation "was discussed with [first name of E4 (ADON)]."</p> <p>During an interview with E8 (CN) on 6/16/15 at 9:30 AM when asked what happens if the doctor does not respond to the call or fax, E8 said if it is a Monday we call the NP. E8 added that staff call the office since the facility does not have E9's cell number. If the doctor does not respond, we keep calling. Depending on the resident's condition, we'll call 911. E8 added that "he's [E9] the only doc [doctor] we have." E9 is the primary physician for all residents and is the Medical Director as well.</p> <p>During an interview with E2 (DON) on 6/16/16 at 9:55 AM E2 confirmed the facility did not have a policy for notification of physician or the or process if the physician did not respond timely.</p> <p>During an interview with E3 (LPN) on 6/16/16 at 1:20 PM the nurse indicated that E9 often does not respond in a timely manner and frequently E9's response is "to monitor" the resident.</p> <p>During an interview with E9 on 6/16/16 at 2:36 PM when asked about the expectation for response when the facility calls, E9 stated "1.5 hours." The physician proceeded to say that if he doesn't respond after the first call, the facility should call a second time (to the office during the day). If a third call is needed the facility should go</p>	F 501	<p>and the MD will take place to review challenges and changes in treatment regarding resident care. The DON/ADON will review changes in condition daily for one month and then monthly for three months or until 100% compliance is met.</p> <p>4. A quality improvement audit will be completed weekly for one month and then monthly for three months or until 100% compliance is met (Attachment J). The results of the audit will be reported at the quarterly Quality Improvement Committee meeting by the DON/ADON.</p>		

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F 501	<p>Continued From page 28</p> <p>through the answering service to have him paged. E9 indicated the delay in response may be due to a dead cell phone battery or that the phone being locked in the car. According to the physician the process of contacting by fax or phone had been working well.</p> <p>The medical director failed to:</p> <ul style="list-style-type: none"> <li>- respond in a timely manner to a fax from the facility regarding the change of condition for R1. Response time by E9 was 4 hours.</li> <li>- develop policies that provided specific guidance for physician coverage including time lines and guidance for physician coverage.</li> </ul> <p>2. Review of R2's clinical record revealed:</p> <p>R2's 6/7/16 (2:27 PM) nursing note - E9 (MD) made aware of bloody urine from previous shift. Family reported at 10:00 AM that the resident had not urinated since last night. Medication nurse assessed the resident's bladder, R2 denied pain or pressure upon palpation, denied flank pain, bowel sounds positive and bladder was non-palpable. E8 (CN) was called at 11:02 AM and faxed at 11:24 AM. MD was called again at 1:01 PM and 1:48 PM. E9 responded at 2:03 PM per fax (over 3 hours after the first telephone call), gave no new orders, but notified the nurse he would be in tonight to see R2.</p> <p>6/7/16 (3:20 PM) nursing note - Orders given by E9 for STAT blood tests and straight catheterization. If more than 350 mL in the bladder to leave catheter in place. Wife was notified of the orders and informed the nurse the son spoke with the physician who performed the abdominal aortic aneurysm repair 5/20/16 and that doctor wanted R2 taken to the emergency</p>	F 501		

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FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>085053</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/17/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>CADBURY AT LEWES</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>17028 CADBURY CIRCLE</b> <b>LEWES, DE 19958</b>		
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F 501	<p>Continued From page 29</p> <p>department right now. The resident, who was his own responsible party, was asked if he would like to be seen at the emergency department and responded yes. R2's son was informed the facility would get the paperwork ready. While printing the papers the nurse saw the family wheeling R2 to the elevator in a wheelchair. The family was asked to wait for the paperwork that the hospital would need but the son stated "I'm not waiting. I'm getting my father out of here. He is having trouble breathing." The nurse noted no oxygen tank was hooked up to R2's oxygen tubing and asked the family to "let us help". As the elevator door was closing the son stated they were calling 911. E9 made aware.</p> <p>During an interview with E2 (DON) on 6/16/16 at 9:55 AM when the surveyor asked for the policy about physician notification and/or chain of command, E2 confirmed the facility does not have a policy. E2 stated if the doctor does not call back, E2 might call the NP in his office.</p> <p>During an interview with E9 on 6/16/16 at 2:36 PM when asked about the expectation for response when the facility calls, E9 stated "1.5 hours." The physician proceeded to say that if he doesn't respond after the first call, the facility should call a second time (to the office during the day). If a third call is needed the facility should go through the answering service to have him paged. E9 indicated the delay in response may be due to a dead cell phone battery or that the phone being locked in the car. According to the physician the process of contacting by fax or phone has been working well.</p> <p>The medical director failed to: - respond to in a timely manner for R2 who</p>	F 501			

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F 501	Continued From page 30 experienced an onset of bloody urine. Response time was 3 hours. - develop policies pertaining to physician notification and /or chain of command when the only physician does not return a call. ?	F 501		
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 determined that the facility failed to maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized for two (R2 and R1) out of 3 sampled residents. For R2 skilled nursing clinical notes included urine clarity but lacked urine color 8 out of 17 documentations; date of	F 514	This plan of correction has been prepared pursuant to the provisions of both Federal and State laws. Preparation and/or execution of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies.  1. Residents R1 and R2 have been	7/15/16

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F 514	<p>Continued From page 31</p> <p>last bowel movement [BM] was either missing or incorrect for 14 out of 17 assessments; and closed record contained rehabilitation documentation from another resident. For R1 and R2 handwritten physicians orders did not consistently have the time the order was written. Findings include:</p> <p>1. Review of R2's skilled nursing clinical notes from 5/27/16 through 6/7/16 revealed: A. Urine color was missing for 8 out of 17 (47%) entries even though the urine clarity was described as clear for these assessments, including the bloody urine on evening of 6/6/16: - May 29 and 30. - June 2, 3 (two shifts), 4, 5 and 6.</p> <p>B. Date of last bowel movement date was either missing or in conflict when compared to CNA documentation for 14 out of 17 (82%) entries: - Missing date: May 29, June 4 and 5. - Incorrect date (all assessments recorded last bowel movement as 5/29/16): May 28, 30 (two shifts), and 31 (two shifts); June 1 (two shifts), 2 (two shifts) and 3 (two shifts).</p> <p>Review of CNA bowel movement documentation recorded the resident did not have a bowel movement on May 29. Bowel movements recorded with documentation times as follows: May 27: large BM (2:40 AM) and medium (12:07 PM). May 28: large (1:24 PM). May 31: medium (1:42 PM). June 1: medium (1:06 AM). June 3: medium (9:01 PM). June 6: large (1:31 PM).</p> <p>During an interview with E5 (Staff Development)</p>	F 514	<p>discharged from the facility.</p> <p>2. A focus review of all current residents' charts has been completed by the DON/ADON to ensure that all orders are complete. A focus review of all residents bowel movement records has been completed by the DON/ADON to ensure that the bowel protocol is being followed (Attachment K).</p> <p>3. A two day education session has been completed for nursing staff by HealthMEDX regarding changes to the EMR system which enhance resident documentation and staff education. This provides easier access to clinical information in the EMR (Attachment L). An enhanced daily skilled nurses note has been added to the existing assessment note in the EMR by the Staff Developer that guides the nurses through a head to toe assessment and documents specific changes in resident conditions. The enhanced skilled nursing note allows additional documentation for color and consistency of the resident's urine (Attachment E). A skills checklist has been completed for the charge nurse to review documentation including CNA documentation for bowel movements. The checklist will be completed each shift by the charge nurse as part of the daily assignment. Completion of the checklist is an ongoing process (Attachment F).</p> <p>4. A quality improvement audit will be completed weekly for one month and then monthly for three months or until 100%</p>	

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F 514	<p>Continued From page 32</p> <p>on 6/15/16 at 11:59 AM the surveyor discussed the fact that 14 assessments recorded the same date for the last bowel movement and asked if prior nurse's answer can be pulled into the screen when documenting on the assessment. E5 stated the nurse completing the assessment can view the previous nurse's answers but cannot pull in the information from the previous assessment.</p> <p>During an interview with E3 (LPN) on 6/16/15 at 9:40 AM to discuss how the nurse obtains the information regarding urine color and bowel movement date, E3 stated the urine color and clarity is personally seen or "I'll track down the aide" to question them for the information. Same with bowel movements, "either I know they went, or I will check with the aide."</p> <p>During an interview with E3 (LPN) on 6/16/16 at 1:20 PM E3 showed the surveyor where/how urine color is documented on the Skilled Note Clinical Note screen in the computer. The urine color question was located in the middle of the screen while all other urine related questions were positioned on the left side of the screen. The question allowed for selection of the following urine colors: amber, orange, straw, tea and bloody. E3 stated that day shift documents on residents in even rooms and evening shift documents on residents in odd rooms. The overnight shift does not document but should write a note if something unusual happens.</p> <p>During an interview with E2 (DON) on 6/17/16 at 10:58 AM E2 stated changes to documentation is in the works, "the computer people are due here next week." E2 confirmed the facility will be having some changes made since there had been glitches in the software, including ADLs,</p>	F 514	compliance is met (Attachment M).	

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F 514	<p>Continued From page 33</p> <p>bowel movements, skilled nursing clinical note. E2 stated that bowel movement data from CNAs did not flow over to the skilled nursing clinical note.</p> <p>The facility failed to document urine color 47% of the time and an accurate last bowel movement date 82% of the time for R2.</p> <p>The findings were reviewed with E1 (ED) and E2 on 6/17/16 at 1:30 PM.</p> <p>2. The paper physicians' order sheet included an area for the date and time to be written when the order was written, when the order was transcribed and when acknowledged by the nurse.</p> <p>A. The following sections on R2's physicians' order sheet were dated but untimed: - 5/26/16: orders written by E9 (Physician/MD), transcription and nurse -acknowledgement. - 5/27/16: verbal order written by physical therapy, transcription and nurse acknowledgement. - 5/30/16: orders written by E9. - 6/5/16: verbal order written by nursing, transcription and nurse acknowledgement. - 6/6/16: order written by E9, transcription and nurse acknowledgement. - 6/6/16: telephone order written by nursing, transcription and nurse acknowledgement.</p> <p>B. The following sections on R1's physicians' order sheet were dated but untimed: - 5/19/16: orders written by E9 (Physician/MD) and transcription. Acknowledgement section blank with no name, date or time</p>	F 514		

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F 514	<p>Continued From page 34</p> <p>- 5/23/16: orders written by E9 (Physician/MD). Transcription with no date or time. Acknowledgement section blank with no name, date or time.</p> <p>- 5/23/16: telephone order written by nursing. Transcription with no date or time. Acknowledgement section blank with no name, date or time.</p> <p>5/23/16: verbal order written by nursing, transcription and nurse acknowledgement.</p> <p>5/26/16: orders written by E9 and nurse acknowledgement.</p> <p>5/30/16: verbal order written by dietitian and acknowledgement. Transcription with no date or time.</p> <p>5/30/16: orders written by E9, transcription and nurse acknowledgement.</p> <p>6/5/16: verbal order written by nursing, transcription and nurse acknowledgement.</p> <p>6/6/16: orders written by E9, transcription and nurse acknowledgement.</p> <p>During an interview with E2 (DON) on 6/16/16 at 10:37 AM while discussing the untimed orders on the paper physicians' order sheet E2 stated "That had been a problem", but not since orders are written in the computer. [When orders were written on the paper form and not entered directly into the computer, they still needed times.]</p> <p>The findings were reviewed with E1 (ED) and E2 on 6/17/16 at 1:30 PM.</p> <p>3. Review of R2's closed record discovered rehabilitation reports (OT Progress Report dated 5/17/16 and OT Treatment Encounter dated 5/27/16) belonging to another resident.</p>	F 514			

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F 514	<p>Continued From page 35</p> <p>During an interview with E7 (Rehabilitation Director) on 6/15/16 at 10:38 AM the surveyor requested physical therapy reports for R2 and informed E7 about the incorrect documents in R2's paper chart. E7 stated that someone will print and deliver the desired information and when that person delivers they can retrieve the documents belonging to another resident so they can get in the right chart. At 10:46 AM E10 (Rehabilitation staff) delivered R2's reports and took the other resident's reports after verifying it contained a different name.</p> <p>During an interview with E2 on 6/17/16 at 9:40 AM the surveyor informed E2 about the aforementioned incident and how it was handled.</p> <p>The findings were reviewed with E1 (ED) and E2 on 6/17/16 at 1:30 PM.</p>	F 514			



**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 Lewes**

**DATE SURVEY COMPLETED: June 17, 2016**

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
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<p><b>3201</b></p> <p><b>3201.1.0</b></p> <p><b>3201.1.2</b></p>	<p><b>The State Report incorporates by reference and also cites the findings specified in the Federal Report.</b></p> <p>An unannounced complaint survey was conducted at this facility from June 14, 2016 through June 17, 2016. 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 thirty seven (37). The complaint sample totaled three (3) residents.</p> <p><b>Regulations for Skilled and Intermediate Care Facilities</b></p> <p><b>Scope</b></p> <p><b>Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.</b></p> <p><b>This requirement is not met as evidenced by: Cross Refer to the CMS 2567-L survey completed June 17, 2016: F157, F309, F389, F501, and F514.</b></p>	<p>Cross reference ePOC dated 6/17/16</p>	<p>7/29/16</p>
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Provider's Signature  Title Executive Director Date 8/2/2016