

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

PRINTED: 04/10/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085052	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/23/2012
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NAME OF PROVIDER OR SUPPLIER CADIA REHABILITATION - RENAISSANCE	STREET ADDRESS, CITY, STATE, ZIP CODE 26002 JOHN J WILLIAMS HIGHWAY MILLSBORO, DE 19966
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	INITIAL COMMENTS An unannounced annual and complaint survey was conducted at this facility from March 12, 2012 through March 23, 2012. 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 116. The Stage 2 sample totaled 51 residents.	F 000	F 000 1. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State Law.	4-25-12
F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation, and interview it was determined that the facility failed to make prompt efforts to resolve grievances for two (R207 and R39) out of 51 sampled residents. R207 reported missing his dentures and R39 reported missing her black velvet skirt and white silk blouse. Findings include: The facility's policy and procedures titled "Resident Concerns/Grievances" stated "All concerns/grievances reported by a resident, responsible party, or family member will be investigated and resolved. Follow-up will be reported to the resident and/or reporting party."	F 166 F 166	1. (A) R207 was provided with information on how to replace his dentures (March 30, 2012) (B) R39 family was contacted and they refused reimbursement for the skirt (March 30, 2012) (C) E4 was educated to immediately turn in concern forms after receiving the complaint (3/14/12). 2. All residents have the potential to be affected by this deficient practice. 3. (A) The Staff Developer will educate Unit Managers and Supervisors to place concern forms in the Nursing Home Administrators mailbox by the end of their shift (date) (B) The Nursing Home Administrator will review concern forms daily in the morning meeting. The Nursing Home Administrator will resolve complaints within one week of receiving the complaint (April 25, 2012). 4. (A) The Nursing Home Administrator/designee will conduct random audits on concern forms to monitor for five day follow up (Attachment 1) (April 25, 2012). (B) Audits will be reviewed by the QA committee until substantial compliance is achieved (April 25, 2012).	4-25-12 4-25-12 4-25-12 4-25-12
	1. Review of R207's clinical record revealed he was admitted to the facility on 2/27/12 with			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Debra Miller NHA</i>	TITLE	(X8) DATE 4-13-12
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 166	<p>Continued From page 1 dentures. On 3/6/12, a "Resident Concern/Compliment Form" was written by E8 (LPN) stating R207 lost his upper dentures.</p> <p>On 3/13/12 at 10:44 AM, R207 stated his upper dentures had been missing for a long time and he wanted them replaced.</p> <p>An interview with E8 on 3/19/12 at 9:42 AM revealed that she filled out the concern form and gave the form to the unit manager.</p> <p>An interview with E4 (RN unit manager) at 10:20 AM on 3/19/12 revealed she failed to give the concern form about R207's missing dentures to the Administrator until 3/19/12 (13 days later).</p> <p>Review of this incident on 3/19/12 at 1:20 PM with E1 (Administrator) confirmed the facility failed to resolve R207's grievance concerning his missing upper dentures.</p> <p>2. R39 reported to the surveyor on 3/13/12 at approximately 11:33 AM that in December 2011, she reported to the facility that she was missing a velvet skirt and white silk blouse and it remained missing.</p> <p>An interview with E5 (Director of Activities) on 3/22/12 at approximately 2 PM revealed that she recalled that R39 was missing the above two clothing items, however, E5 did not recall whether she completed a "Resident Concern/Compliment Form" to document the missing items.</p> <p>An interview with E33 (Director of Housekeeping) on 3/22/12 at approximately 3 PM revealed that</p>	F 166		
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[Handwritten Signature], N/A 4-13-12

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F 166	Continued From page 2 he did not recall receiving the above "Resident Concern/Compliment Form" related to the above missing clothes. An additional interview with E34, who retained a log of missing items on 3/22/12 at approximately 3:15 PM revealed that she was not aware of the above missing items of clothing.	F 166		
F 225 SS=D	Findings were reviewed with E1 and E3 (Director of Nursing on 3/22/12 at approximately 2 PM. 483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must	F 225	F 225 1. R72 no longer resides in the facility (April 6, 2012). 2. All residents have the potential to be affected by this deficient practice. 3. (A) The Staff Educator will reeducate the Nursing Home Administrator that all potential/alleged abuse incidents are to be sent to the State Agency within 84-25-12 hours and follow up will be completed within 5 days. (B) The Nursing Home Administrator will review all investigations to monitor for thoroughness and follow up (April 25, 2012). 4. (A) The Nursing Home Administrator/designee will conduct random audits of investigation forms to 4-25-12 monitor for thoroughness and follow up (Attachment 1) (April 25, 2012). (B) Audits will be reviewed by the QA committee until substantial compliance is achieved (April 25, 2012).	

Dava Smiles 4-13-12
NRS

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F 225	<p>Continued From page 3</p> <p>prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, interview and review of the facility's policy and procedures it was determined that the facility failed to report to the State Agency an allegation of abuse and failed to conduct a thorough investigation for one (R72) out of 51 sampled residents. Findings include:</p> <p>The facility's Investigation Protocol stated the facility will assure all alleged violations involving abuse, neglect, mistreatment, financial exploitation, misappropriation of resident property and injury of unknown origin per the Federal regulations will be reported immediately (within 8 hours) to Administrator/Designee and State." The policy and procedure for Investigation Protocol documented steps on conducting a thorough investigation.</p> <p>R72 was admitted to the facility with diagnoses that included Alzheimer's dementia, bipolar, schizophrenia, and hypertension.</p> <p>Interview with E3 (Director of Nursing) on 3/22/12</p>	F 225		
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Diana Smiles VHA 4-13-12

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F 225	<p>Continued From page 4</p> <p>at 10:50 AM revealed on 2/27/12, a concern was brought to the facility by the family member stating R72 was found in her bed naked. R72's night gown and diaper were found in a pile in the middle of the floor. A concern form was written and given to E3 and she stated she investigated this concern. However, E3 could not find this concern form or documentation of the investigation.</p> <p>During an interview at 11:45 AM on 3/22/12 E4 (RN Unit Manger) stated that R72's family mentioned to her that when R72 was found naked in her bed she also complained of pain in her rectum. E4 continued to state the family stated they reported it to the facility so she did not think she needed to write up a Concern Form for this allegation of abuse.</p> <p>An interview with E1 (Administrator) revealed at 12:00 noon on 3/22/12 that she spoke with the family. E1 stated that the family said they reported to E2 (previous administrator) that R72 was found in bed with no clothes on and that R72 told the family that "he shoved something up my rectum and it hurt." The family requested E2 to schedule a rectal and vaginal exam for R72. E2 told the family that no males were working that night. So the family agreed not to have the rectal or vaginal exam completed. E1 continued to state that the family are now saying they are sorry they did not have it done.</p> <p>E1 stated she looked for the concern form or the incident report for this allegation of sexual abuse that was sent to E2 and it was not found. Both E1 and E3 confirmed that the facility failed to immediately notify the state agency and failed to</p>	F 225		
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Dana Smiles NHA 4-13-12

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F 225	Continued From page 5 do a thorough investigation for this allegation of sexual abuse and consequently failed to complete a follow-up.	F 225		
F 226 SS=E	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, review of the facility's policy and procedures, interview and clinical record review it was determined that the facility failed to protect one (R295) out of 51 sampled residents from a staff member when an allegation of abuse was made. The facility also failed to provide abuse prohibition training for 32 out of 119 (27%) of their staff on an annual basis. Findings include:</p> <p>The facility's policy entitled "Abuse/Neglect" dated 9/1/05 stated, "...3. If you witness an abusive act, you must first remove the source of the mistreatment, whether it is a staff member or a visitor, and then protect the resident."</p> <p>1. The facility's policy and procedures for "Abuse and Neglect/Staff Training" stated ..."2. a. All employees, upon hire, and annually thereafter will receive mandatory training on issues related to abuse prohibition practices.."</p> <p>Review of the staff education for Abuse and Neglect revealed out of 119 employees 32</p>	F 226 F226	<ol style="list-style-type: none"> (A) R295 no longer resides in the facility (March 24, 2012). (B) E7 and E10 will be educated on the facility's Abuse/Neglect policy which includes removing the source of mistreatment (April 25, 2012). (A) All residents have the potential to be affected by this deficient practice. (B) The Staff Educator will audit all staff files to monitor for evidence of abuse training (April 25, 2012) (A) The Staff Educator will educate all staff members that are deficient in abuse training which includes removing the source of mistreatment (April 25, 2012). (A) The Human Resource Director/designee will conduct random audits on employee files to monitor <p>for evidence of abuse training (Attachment 2) (April 25, 2012). (B) Audits will be reviewed by the QA committee until substantial compliance is achieved (April 25, 2012).</p>	<p>4-25-12</p> <p>4-25-12</p> <p>4-25-12</p> <p>4-25-12</p>

Alana Smiles, OHA 4-13-12

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F 226	<p>Continued From page 6</p> <p>employees (27%) were not current for their annual training on abuse and neglect. E7 (RN) was one of the 32 employees that was not current with her training. E7's training was due to be completed in April 2011.</p> <p>Review of the education with E6 (RN staff educator) confirmed the above information on 3/21/12 at approximately 11 AM.</p> <p>2. R295 was admitted to the facility on 3/11/12 with diagnoses that included hypertension, coronary artery disease, cerebral vascular accident, depression with anxiety and hypothyroidism.</p> <p>On 3/14/12 at approximately 9:40 AM a surveyor was sitting at the nurses station when loud screaming was heard coming from R295's room. At 9:42 AM E7 (RN) entered the room with two surveyors. R295 was in bed with her pants half pulled up with a diaper and a shirt on. R295 was yelling and crying. The resident stated that E9 (CNA) was being "rude to me" and "she is not treating me in a dignified manner." E7 told E9 (accused) that she should have walked away and come back later to finish care. E9 stated the sheets were wet and needed to be changed. Resident stated it is not my fault (referring to the wet sheets). E7 was able to calm R295 down within a few minutes. The surveyors left the room with E7 leaving E9 with R295 after R295 stated it was ok for the surveyors to leave. A few minutes later E7 left E9 in the room with R295 alone. E10 (Corporate LPN) went in the room when she realized E7 was left E9 alone with R295. However, E7 nor E10 removed E9 from R295's care.</p>	F 226		
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Debra Smiles NTR

4-13-12

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F 226	Continued From page 7	F 226		
F 241 SS=D	<p>On 3/14/12 at approximately 10:15 AM, E3 (DON) was made aware that E9 continued to provide care to R295 in the dining room even though an allegation of abuse was made against E9 by the resident. E3 immediately removed E9 from R295's care. The facility confirmed that E9 should have walked away and returned later when R295 became upset. They also confirmed that E9 should have been removed from R295's care immediately until a thorough investigation of the allegation of abuse was completed.</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and record review, it was determined that the facility failed to provide meal service and routine care in a dignified manner for two residents (R198 and R91) out of 51 residents sampled. Findings include:</p> <p>1. The Rehoboth Unit Manager, E7 gloved and gowned herself to deliver a lunch tray to R198 who was on isolation for a MDRO (Multi Drug Resistant Organism) in a wound on the right heel. This wound was being treated and was contained. This resident was alert and oriented to person, place, and time. The staff did not come into contact with the resident or the resident's environment, except to walk into the room and</p>	F 241 F241	<ol style="list-style-type: none"> Nursing staff and Certified Nursing Assistants provided with cue cards with isolation precautions for the resident posted (April 25, 2012) 4-25-12 All residents have that are on isolation precautions have the potential to be affected by this deficient practice (April 25, 2012). 4-25-12 (A) The facility will place a "cue card" outlining the proper precautions that need to be implemented for each resident that is on isolation. The "cue card" will be placed in the top draw of the resident's Isolation Cart (April 25, 2012). 4-25-12 (A) The D.ON./designee will conduct random audits of residents that are on isolation to monitor for proper precautions (Attachment 3) (April 25, 2012). (B) 4-25-12 <p>Audits will be reviewed by the QA committee until substantial compliance is achieved (April 25, 2012).</p>	

Dana Smell, NHA

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F 241	<p>Continued From page 8 place the tray on the table.</p> <p>2. R91 was hospitalized from 3/6/12-3/12/12 and returned on contact isolation for VRE (vancomycin-resistant enterococci, is not spread through the air by coughing or sneezing) of the urine.</p> <p>On 3/13/12 at approximately 9:40 AM a nurse, E18 was observed dressed in gloves, gown and mask entering the room to administer R91 an oral medication from a spoon.</p> <p>Upon interview with unit manager E19 on 3/22/12 at 9:50 AM concerning R91's isolation and review of isolation policies, she stated all nursing staff are given report on anyone on isolation and they may have assumed wearing masks were necessary because it was in the cart. She confirmed that R91's condition did not require a mask and that there were no isolation guidelines in the cart so all staff would know what protective apparel to wear.</p> <p>Findings reviewed with E3-DON on 3/22/12 at approximately 2:00 PM.</p>	F 241		
F 248 SS=D	<p>483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES</p> <p>The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced</p>	F 248	<p>F248</p> <ol style="list-style-type: none"> R72 no longer resides in the facility (April 6, 2012). (A) All residents that participate in activities have the potential to be affected by this deficient practice. (B) The Activities Director will audit all residents care plans to monitor for individualization, and will correct accordingly (April 25, 2012). 	<p>4-25-12</p>

Dana Smiles NHA

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F 248	<p>Continued From page 9</p> <p>by: Based on clinical record review, observation and interview it was determined that the facility failed to provide an individualized activity program for one (R72) out of 51 sampled residents. Findings include:</p> <p>R72 had a care plan stating resident prefers independent pursuits such as reading-newspaper, mail, daily activity schedule, socializing with staff & peers, social visit with family & staff, watching television programs and conversing on the telephone. Her own room and on unit as the preferred leisure setting. R72 was assessed as being cognitively impaired.</p> <p>R72 was observed either sitting in the center of the unit or in the dining area on 3/13/12, 3/14/12, 3/19/12 by one or more surveyors. On 3/19/12 from 12:02 PM through 3 PM, R72 was observed by one or more surveyors in the dining room with her back to the television and again on 3/20/12 from 11:30 AM until 2:30 PM. No other activities were observed.</p> <p>On 3/20/12 at 2:50 PM an interview with E5 (Activity Director) revealed entertainment was scheduled for the residents in the rehabilitation (rehab.) unit (Rehoboth Unit) every Saturday as they are busy doing rehab. during the week. E5 stated she did one on one visits with R72 in her room going over the events of the day in the mornings. Review of the activities documentation revealed R72 was taken off her unit for a musical entertainment on 3/16/12 at 2:30 PM. E5 continued to state that she considered the TV on while R72 is eating her meals as an activity. However, E5 failed to ask R72 if she liked</p>	F 248	<ol style="list-style-type: none"> The Activities Director will educate her staff on the need to individualize resident's activity care plan. Individual resident preferences for individual pursuits will be accommodated whenever possible (April 25, 4-25-12 2012). The Activities Director will conduct random audits of resident's to monitor for individualization (Attachment 4) (April 25, 2012). (B) Audits will be reviewed by the QA committee until substantial compliance is achieved (April 25, 2012). 	4-25-12
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Wanda Smiles NNA 4-13-12

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NAME OF PROVIDER OR SUPPLIER CADIA REHABILITATION - RENAISSANCE			STREET ADDRESS, CITY, STATE, ZIP CODE 26002 JOHN J WILLIAMS HIGHWAY MILLSBORO, DE 19966	
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F 248	Continued From page 10	F 248		
F 279 SS=D	watching the program on the TV. She also confirmed that she did not provide an individualize activity program for R72. 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 review and interview it was determined that for one (R1) out of 51 sampled resident the facility failed to develop a care plan for the assessed need of oral care for a resident dependent on staff for personal hygiene. Findings include: Cross refer F312 example #3.	F 279 F279	1. (A) R1 Activities of Daily Living Care Plan and his C.N.A. flow sheet has been updated to reflect his mouth care (April 13, 2012). 4-25-12 2. (A) All residents that trigger on the Minimum Data Assessment for dental needs are at risk for this deficient practice. (B) The RNAC/designee will audit care plans and C.N.A. flow books for residents that have had a Minimum Data Assessment over the past year and who have triggered for dental needs. Corrections to care plans and C.N.A. flow books will be made accordingly (April 25, 2012). 4-25-12 3. (A) The RNAC will care plan residents who trigger on the Minimum Data Assessment for dental needs without pain on the Activities of Daily Living care plan (April 25, 2012). (B) The RNAC will care plan residents who trigger on the Minimum Data Assessment for dental needs with pain on a Dental Care Plan (April 25, 2012). (C) The Unit Manager/designee will update C.N.A. flow books with the dental needs of residents that trigger on Minimum Data Assessment (April 25, 2012) 4-25-12 4. (A) The Unit Manager /designee will conduct random audits of care plans and C.N.A. flow books on residents who trigger for dental needs on the Minimum Data Assessment to monitor for proper documentation(Attachment 5.) (April 2, 2012) . (B) Audits will be reviewed by the QA committee until substantial compliance is achieved (April 25, 2012). 4-25-12	

Debra Smiles 4-13-12
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F 279	Continued From page 11 R1's annual Minimum Data Set assessment dated 7/29/11 indicated that the resident was tube fed, dependent on staff for personal hygiene and had cavity or broken teeth. The assessment triggered for dental needs but the facility chose not to proceed with care planning. The resident had quarterly oral assessments dated 5/25/11 and 12/1/11 which indicated the presence of fractured/missing teeth and plaque. Review of the Certified Nursing Assistants documentation sheet revealed R1 needed mouth care each shift but failed to describe how to provide mouth care for the resident.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. 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	F 280	F280 Example 1 1. R112 no longer resides in the facility (December 28, 2011). <i>4-25-12</i> 2. All residents that convert from a short term stay to a long term stay have the potential to be affected by this deficient practice. <i>4-25-12</i> 3. Residents that convert from short term stay to long term stay will be discussed in the weekly Utilization and Review meeting. The Social Worker will update or initiate care plans accordingly. <i>4-25-12</i>	

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F 280	Continued From page 12 legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to periodically review and revise the care plan for three (R112, R54, and R264) out of 51 residents sampled. Findings include: 1. The admission MDS (Minimum Data Set) assessment dated 11/03/11 and PPS assessment dated 11/23/11 indicated that R112 planned to return to the community. The resident was hospitalized 12/09/11 - 12/11/11. The return PPS MDS assessment dated 12/18/11 documented the resident was expected to be discharged to another long-term care facility. The last PPS assessment dated 12/25/11 documented it was not feasible to discharge to the community. R112 had a care plan for short term stay. The care plan was not updated when the resident was determined to need long-term care and was going to transfer to another long-term care facility. Social Service notes dated 11/22/11 revealed the resident was going to need long-term care and the family was looking at another local facility. Nurses notes revealed on 12/28/11 that R112 left the facility to go to another long-term care facility.	F 280	4. (A) The Social Worker will conduct random audits of care plans residents who covert from short term stay residents to long term residents to monitor that proper placement is reflected (Attachment 7) (April 25, 2012). (B) Audits will be reviewed by the QA committee until substantial compliance is achieved (April 25, 2012). F280 Example 2 1. R54 no longer resides in the facility (December 16, 2011). 2. All residents that have a catheter removed have the potential to be affected by this deficient practice. 3. During the daily morning meeting residents who have catheters removed will be reviewed. The Unit Manager/designee will update or initiate care plans accordingly (April 25, 2012). 4. The RNAC/designee will conduct random audits of residents that had catheters removed to monitor that care plans have been updated (Attachment 6) (April 25, 2012). (B) Audits will be reviewed by the QA committee until substantial compliance is achieved (April 25, 2012). F 280 Example 3 1. R264 no longer resides in the facility (March 28, 2012). 2. All residents that are placed on hydration monitoring have the potential to be affected by this deficient practice.	4-25-12	4-25-12

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F 280	<p>Continued From page 13</p> <p>2. R54 was readmitted to the facility from the hospital on 10/06/11. The reentry MDS, dated 10/13/11, indicated that the resident was occasionally incontinent of bladder.</p> <p>The physician order sheet (POS) on 10/11/11 indicated that the Foley catheter was to be discontinued. The catheter was removed on 10/12/11. The indwelling catheter care plan was initiated on 09/21/11 and was not updated upon removal of the urinary catheter.</p> <p>Interview with the Registered Nurse Assessment Coordinator/RNAC (E38) on 03/20/12 at 10:55 AM, regarding updated care plan revealed that the RNAC agreed there was no updated care plan.</p> <p>3. Cross refer F327. Review of R264's care plan for "risk of fluid output exceeding intake related to diuretic use" included a goal that the resident will not present with signs of dehydration X 90 days and included the following approaches: - encourage fluid consumption and to monitor adequate fluid intake. - monitor resident for signs of dehydration (tenting skin, dry mouth, etc.) - monitor lab work per orders - monitor level of consciousness changes.</p> <p>The readmission blood work at the facility dated 3/7/12 indicated that the resident's blood urea nitrogen (BUN) level was elevated at 28 (normal range 10-26 mg /dl) and that the creatinine (creat.) level was elevated at 2.4 (normal range 0.5-1.5 mg/dl). In addition, the sodium level was</p>	F 280	<p>3. During the daily morning meeting residents who were placed on Hydration Monitoring will be reviewed. The Unit Manager/designee will update or initiate care plans accordingly (April 25, 2012).</p> <p>4. The Registered Dietitian will conduct random audits of residents that are on hydration monitoring to review for update (Attachment 11) (April 25, 2012). (B) Audits will be reviewed by the QA committee until substantial compliance is achieved (April 25, 2012).</p>	4-25-12	4-25-12

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F 280	<p>Continued From page 14</p> <p>within normal at 142 (normal range 135-145 mmol/L). BUN, creatinine, and sodium levels are indicators of fluid imbalance and renal function. On this laboratory document, the attending physician noted that the elevated creatinine result was "chronic."</p> <p>Review of attending physician's order dated 3/12/12 timed 5 PM documented to "Hold fluid restriction X 48 hours", however, review of the above care plan failed to include this new intervention.</p> <p>The repeat blood work dated 3/13/12 PM documented that the resident's BUN and creat. worsened to 45 mg /dl and 3.7 mg/dl respectively. In addition, the sodium level was within normal at 136 mmol/L).</p> <p>An additional verbal physician's order dated 3/13/12 timed 4:46 PM was obtained by E4 (RN Unit Manager) documented " Isolation precaution-C. Diff. (clostridium difficile) Hydration monitoring X 5 days. "</p> <p>Although hydration monitoring (HM) was ordered on 3/13/12, the above care plan failed to include the new intervention.</p> <p>An interview with E4 on 3/22/12 at approximately 11:30 AM revealed that the above order for HM was ordered in response to the elevated BUN on 3/13/12. E4 confirmed that the above care plan did not include the intervention for HM, however, E4 related that she did not feel that this new intervention needed to be included in the care plan. An interview with E3 (Director of Nursing) on 3/22/12 at approximately 2 PM confirmed that</p>	F 280		

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F 280	Continued From page 15 when the orders were written to "hold fluid restriction for 48 hours" and "hydration monitoring X5 days" on 3/12/12 and 3/13/12 respectively, the above care plan should have been updated to include these new interventions.	F 280		
F 309 SS=E	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation and interview it was determined the facility failed to ensure that three (R201, R207, and R295) out of 51 sampled residents received the necessary care and service to maintain their highest physical, mental and psychosocial well being. R207 was on nectar thicken liquids and was offered thin liquids. The facility failed to administer a new scheduled pain medication according to the plan of care when R201 experienced unrelieved pain of the right shoulder. R295 had trouble chewing and swallowing and the facility failed to ensure the diet was downgraded from a regular diet to a mechanical soft. Findings include:</p> <p>1. R201 was admitted to the facility on 10/11/11 with diagnoses including acute renal failure, diabetes mellitus type II, hypertension,</p>	F 309	<p>F 309 Example 1</p> <ol style="list-style-type: none"> 1. R201 no longer resides in the facility (March 29, 2012). 2. (A) Any resident that is prescribed an analgesic medication has the potential to be affected by this deficient practice. (B) The D.O.N./designee will complete a full house sweep on residents that are prescribed analgesic medications to monitor that the medication was transcribed into the paper MAR with the correct start date and time (April 25, 2012). <i>4-25-12</i> 3. The D.O.N./designee will check new analgesic medication orders for correct transcriptions into the paper MAR to include the correct start date and time (April 25, 2012). <i>4-25-12</i> 4. The D.O.N./designee will conduct random audits of analgesic pain medications to monitor for correct transcriptions to include correct start date and time (Attachment 9) (April, 25, 2012). (B) Audits will be reviewed by the QA committee until substantial compliance is achieved (April 25, 2012). <i>4-25-12</i> 	

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F 309

Continued From page 16
hypothyroidism, cerebrovascular disease, and encephalopathy.

Admission Minimum Data Set (MDS) assessment dated 10/18/11 documented that R201 had no cognitive impairment, was not on a scheduled pain medication regime and received PRN (as needed) pain medication within the past 5 days. Care Area Assessment (CAA) Summary noted that a care plan was implemented for pain. In addition, R201 had experienced the worst pain level of "8" within the past five days with "0" being no pain and "10" being the worst pain imaginable.

Review of the December 2011 electronic Medication Administration Record (eMAR) documented that R201 was administered Tylenol 650 mg. at 7:51 AM and upon reassessment, this intervention was not effective.

R201's Nurse's Note (N.N.) dated 12/30/11 timed 3 PM-11 PM shift documented "MD made aware resident complaint of increase pain at right shoulder, unrelieved with Tyl. (Tylenol) N.O. (new order) Tramadol (indicated for the short-term management of acute pain). See MAR (Medication Administration Record). Pt. (Patient) stable this shift."

Physician's order obtained on 12/30/11 (without time) during the evening shift on 12/30/11 documented "Tramadol 50 mg. (milligram) po (by mouth) TID (three times a day) for one week.

Review of the eMAR record revealed that the above new Tramadol order was transcribed in the eMAR system on 12/30/11 at 6:51 PM, however, the start date and time for this new medication

F 309

F309
Example 2

1. (A) Once the surveyor informed the facility of the problem R207 was provided with nectar thickened liquids (February 27, 2012). (B) E4 was re-educated on checking liquid consistencies orders before providing fluids to residents (February 27, 2012). *4-25-12*
2. All residents that have an order for thickened liquids have the potential to be affected by this deficient practice. *4-25-12*
3. The Staff Educator will educate C.N.A.'s and Nursing staff to check diet order before providing fluids to residents (Attachment 8) (April 25, 2012). *4-25-12*
4. (A) The Rehab Director/designee will conduct random audits of the liquid consistencies provided to residents at bedside. (B) Audits will be reviewed by the QA committee until substantial compliance is achieved (April 25, 2012). *4-25-12*

F309
Example 3

1. Once the surveyor informed the facility of the problem R295 was provided with the correct diet consistency (March 21, 2012). *4-25-12*
2. (A) All residents that have an altered consistency diet order have the potential to be affected by this deficient practice. (B) The Rehab Director will conduct a full house sweep of residents that have an altered consistency diet order against what dietary is providing. Corrections will be made accordingly (April 25, 2012). *4-25-12*

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4-13-12

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F 309	<p>Continued From page 17 was scheduled for 1/1/12 at 9 AM.</p> <p>There was no N.N. for 12/31/11 or 1/1/11 relating to presence or absence of pain. Review of the "Pain Flow Sheet" documented that R201 reported absence of pain during the night and day shift on 12/31/11, however, there was no documentation related to the evening shift or the night shift on 1/1/12.</p> <p>Further review of the December 2011 eMAR lacked evidence that the new order for Tramadol was implemented on 12/30/11 at 5 PM as ordered and that the first dose was administered on 1/1/12 at 9 AM, thus, the facility omitted a total of four doses of Tramadol: - 12/30/11 at 5 PM - 12/31/12 at 9 AM, 1 PM, and 5 PM.</p> <p>Review of the facility's "Interim Box List" (which contained a list of medication available in this box) documented that Tramadol 50 mg. was available for administration.</p> <p>Findings were reviewed with E1 (Administrator) and E3 (Director of Nursing) on 3/22/12 at approximately 2:30 PM confirmed the above findings.</p> <p>2. R207 was admitted to the facility on 2/27/12 from the hospital with diagnoses that included seizure/epilepsy disorder, anemia, atrial fibrillation, coronary artery disease, and hypertension. On admission R207 had a physician order for nectar thickened liquids with a puree diet and on aspiration precautions. R207 had a sign over his bed for aspiration precautions</p>	F 309	<p>3. The Staff Educator will educate the nursing staff that they have the ability to downgrade diet orders. Additionally, nursing will be educated on providing the Speech Therapist with a request to screen the resident, and submit a diet slip to dietary about the downgrade. (April 25, 2012). <i>4-25-12</i></p> <p>4. The RD/designee will conduct random audits to compare diet orders against the consistency provided by the kitchen (April 25, 2012). (B) Audits will be reviewed by the QA committee until substantial compliance is achieved (April 25, 2012). <i>4-25-12</i></p>	
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F 309	<p>Continued From page 18 keep head of bed up 30 degrees.</p> <p>On 3/19/12 at approximately 9:15 AM a styrofoam cup of thin water was observed on R207's bed table. At 1:45 PM the styrofoam cup of thin water was still present. At 2:05 PM E4 (RN Unit Manager) offered R207 a drink of water while setting him up in bed. The resident refused. E4 stated she would get him fresh ice water. When E4 returned she brought back nectar thickened water. E4 confirmed R207 should have had nectar thickened fluids.</p> <p>3. R295 was admitted to the facility on 3/11/12 with diagnoses that included congestive heart failure, esophageal reflux, anxiety, dementia with behaviors, cerebral vascular accident, and osteoporosis. R295 required assistance with eating and was on a regular diet.</p> <p>On 3/21/12 at approximately 1:00 PM R295 did not eat her lunch even with the encouragement of the family. R295 stated she could not chew the food and it was hard to swallow. E20 (CNA) told the family and the surveyor that she would ask the nurse if she would order a mechanical soft diet and speech therapy evaluation.</p> <p>On 3/22/12 at 12:25 PM E21 (CNA) was observed feeding R295. E21 stated R295 was having trouble chewing her food and swallowing her food. She continued to state that R295 seemed to be pocketing her food. Upon reviewing R295's menu it was noted that she received a regular diet that included chicken.</p> <p>Review of the information that E20 reported to E22 (RN) revealed there was documentation</p>	F 309			

Debra Smiles NAK 4-13-12

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085052	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/23/2012
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F 309	<p>Continued From page 19</p> <p>written by E22 about c/o (complaint of) throat and mouth hurting and unable to chew per staff. The facility failed to ensure that R295's diet was down graded to a mechanical soft diet on 3/22/12 when the problem was first identified.</p> <p>On 3/22/12 at 12:30 PM, E7 (RN) called the kitchen and changed R295's diet to mechanical soft. E7 stated that a nurse did not require a speech therapy evaluation or physician order to down grade a diet. E7 continued to state that the nurses need education letting them know they can down grade a diet for a resident's safety without an order from the physician or a speech therapy evaluation.</p> <p>This information was also reviewed with E3 (DON) who also confirmed nursing could down grade the residents diet as a nursing intervention without a physician order or speech therapy order.</p>	F 309		
F 312 SS=E	<p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</p> <p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation, and interview it was determined that the facility failed to ensure that three (R118, R207 and R1) out of 51 sampled residents received the necessary services to maintain grooming, personal and oral</p>	F 312	<p>F312 Example One and Example Two</p> <ol style="list-style-type: none"> (A) R118 and R207 have been groomed (April 13, 2012. (A) All residents have the potential be affected by this deficient practice. (B) The D.O.N./designee will do a full house sweep of toenails and fingernails. Podiatrist recommendations and nail grooming will be made accordingly. The Staff Educator will educate the nursing staff to assess and document the status of toenails and fingernails during skin assessments (April 25, 2012). 	<p>4-25-12</p> <p>4-25-12</p> <p>4-25-12</p>

Dana Smiles NHA 4-12-12

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F 312

Continued From page 20
hygiene. The facility failed to provide for nail care for R207 and R118. In addition, the facility failed to provide oral hygiene for R1. Findings include:

- R118 was admitted to the facility on 1/12/12 then readmitted to the facility on 3/11/12. The nurse practitioner documented on 3/15/12 that R118 heels were boggy with blanching. On 3/16/12 at 1:00 PM an observation was done with E6 (RN) of R118's feet for pressure ulcers and open wounds. While observing R118's toes, it was noted that her 2nd and 3rd toe on the right foot had long toe nails that grew over the top of the toe curling under the toes. E6 stated she would put R118's name on the podiatrist's list. E6 also confirmed that while doing wound rounds and skin assessments the staff should have identified R118's long toe nails.
- R207 was admitted to the facility on 2/27/12. The initial skin assessment documented R207 had red heels. R207's care plan for the potential for pressure ulcer development included the interventions that R207 would have skin checks on the 3-11 shift on Tuesdays and weekly Braden assessments on Tuesdays 3-11 x 4. R207 required the one person to assist him with his activities of daily living.

On 3/19/12 at 1:55 PM an observation was completed with E4 (RN unit manager). R207's toe nails were very long growing over top of his toe and curling under them. R207 told E4 that his finger nails also needed cutting as they were long and jagged. E4 stated she would put R207's name on the podiatrist list. E4 stated that when staff are assessing residents feet/heels/skin they should also be looking at their toe nails and

F 312

4. (A) The D.O.N./designee will conduct random audits on resident's toenails and fingernails to monitor for proper grooming (Attachment 10) (April 25, 2012). (B) Audits will be reviewed by the QA committee until substantial compliance is achieved (April 25, 2012). *4-25-12*

F312
Example Three

- R1 Activities of Daily Living Care Plan and his C.N.A. flow sheet has been updated to reflect his mouth care (April 13, 2012). *4-25-12*
- (A) All residents that trigger on the Minimum Data Assessment for dental needs are at risk for this deficient practice. (B) The RNAC/designee will audit care plans and C.N.A. flow books for residents that have had a Minimum Data Assessment over the last 90 days and who have triggered for dental needs. Corrections to care plans and C.N.A. flow books will be made accordingly (April 25, 2012). *4-25-12*
- (A) The RNAC will care plan residents who trigger on the Minimum Data Assessment for dental needs without pain on the Activities of Daily Living care plan (April 25, 2012). (B) The RNAC will care plan residents who trigger on the Minimum Data Assessment for dental needs with pain on a Dental Care Plan (April 25, 2012). (C) The Unit Manager/designee will update C.N.A. flow books with the dental needs of residents that trigger on Minimum Data Assessment (April 25, 2012). *4-25-12*

Dana Smiles, NHA 4-13-12

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F 312	<p>Continued From page 21 fingernails.</p> <p>3. R1 had an annual Minimum Data (MDS) Set assessment dated 7/29/11 that indicated cavity or broken teeth. The MDS triggered for dental needs but the facility assessment was to not proceed with a care plan. This MDS and the quarterly MDS assessments dated 10/27/11 and 1/25/12 indicated that the resident was dependent on staff for personal hygiene including mouth care.</p> <p>An oral assessment form dated 5/25/11 indicated that the resident had fractured/missing teeth, plaque and "gums bleed very easily when brushed." There were no recommendations for follow-up care made.</p> <p>An oral assessment form dated 12/1/11 indicted the resident had fractured/missing teeth and plaque with no further recommendations.</p> <p>R1 had a current (March 2012) physician order originating in June 2011 for mouth care every shift and as needed.</p> <p>The resident's care plan for potential for aspiration included an approach of oral hygiene every shift and as needed.</p> <p>On 3/13/12 at 10:30 AM, R1 was observed in his room in bed with mouth odor and broken teeth.</p> <p>An interview on 3/22/12 at 10:40 AM with E30 (Licensed Practical Nurse) revealed that R1 needed staff assistance to clean his teeth. An interview at the same time with the E31, the Certified Nursing Assistant (CNA) who provided</p>	F 312	<p>4. (A) The Unit Manager /designee will conduct random audits of care plans and C.N.A. flow books on residents who trigger for dental needs on the Minimum Data Assessment to monitor for proper documentation (Attachment 5) (April 25, 2012). (B) Audits will be reviewed by the QA committee until substantial compliance is achieved (April 25, 2012).</p>	4-25-12
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Laura Smiles, NHA

4-13-12

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F 312 Continued From page 22
care for R1 daily revealed that a tooth brush is used to clean R1's teeth but at times he will refuse the tooth brush and she will need to use mouth swabs to clean his mouth.

Review of the CNA documentation records for December 2011 and January 2012 revealed that staff signed off each shift (day, evening and night) for mouth care.

Review of the CNA documentation records for February 2012 and March 2012 revealed that only the day and evening shift were documenting mouth care. The night shift entry was missing from the form indicating that mouth care was not done on the night shift.

F 312

F 315 SS=D
An interview on 3/22/12 at 10:50 AM with E32 (Unit Manager) confirmed that the care plan and CNA documentation sheets did not provide specific instructions on R1's oral care needs. E32 also confirmed that there was no evidence that R1 received mouth care during the night shift from February 1, 2012 through March 22, 2012.
483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER

F 315

Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

- F 315**
1. R54 no longer resides in the facility (December 16, 2011). *4-25-12*
 2. (A) All residents that have been catheterized have the potential to be affected by this deficient practice. (B) The RNAC will audit the medical records of residents that have had catheters removed to assess bladder function (April 25, 2012) *4-25-12*
 3. (A) The Staff Educator will educate nursing on how to assess bladder function utilizing a 3-day voiding diary or voiding program to improve bladder function. *4-25-12*

Dana Smalls, NHA

4-13-12

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F 315	<p>Continued From page 23</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to appropriately treat and provide services to restore as much normal bladder function as possible for one (R54) out of 51 residents sampled. Findings include:</p> <p>1. R54 was readmitted to the facility on 10/06/11 with a Foley urinary catheter. On 10/11/11, a physician's order was written to remove the Foley catheter. Nurses notes revealed that the Foley catheter was removed on 10/12/11.</p> <p>Review of the MDS (Minimum Data Set) assessment dated 10/13/11 revealed that the resident had a Foley catheter and was occasionally incontinent of of urine. The CNA (Certified Nursing Assistant) documentation for 10/13/11 to 10/17/11 (after the urinary catheter was removed) indicated the resident was continent of urine for 4 out of 15 shifts reviewed.</p> <p>The resident was re-hospitalized from 10/18/11 to 11/2/11. The return MDS assessment dated 11/9/11 indicated the resident was always incontinent of urine and was not on a toileting plan.</p> <p>An "Assessment For Bowel and Bladder Training" conducted on 11/2/11 documented the resident was incontinent of urine and incomplete in the area of "Appropriate For" resulting in no plan to restore bladder function being put in place.</p> <p>Review of the November 2011 CNA documentation revealed the resident was totally</p>	F 315	<p>4. The D.O.N./designee will conduct random audits to monitor on all residents that have had a catheter removed that bladder assessment was completed either using a 3-day voiding diary or a voiding program in attempt to improve bladder function (Attachment 6) (April 25, 2012). (B) Audits will be reviewed by the QA committee until substantial compliance is achieved (April 25, 2012).</p>	4-25-12

Debra Smiles RHA 4-13-12

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F 315	<p>Continued From page 24 incontinent of urine.</p> <p>R54 had a care plan for the indwelling catheter that was initiated on 9/21/11 but was not revised upon removal of the urinary catheter on 10/12/11 to address bladder function and/or incontinence care.</p> <p>The facility's policy indicated "On admission and quarterly as part of the MDS process, an Assessment for Bowel and Bladder Training form is completed to determine whether a resident will benefit from bladder retraining, scheduled toileting or check and change program." Step one in the policy's procedure is: "Following the completion of the three day voiding/BM diary an Assessment for Bowel and Bladder form is completed by the assigned nursing designee."</p> <p>Record review and interview with E38 (Registered Nurse Assessment Coordinator) on 3/20/12 at 10:55 a.m. revealed a three day voiding/bowel movement diary was not completed for resident R54 after removal of the urinary catheter.</p> <p>R54's "Assessments for Bowel and Bladder Training" were completed on 09/08/11, 10/06/11 and 11/2/11. Of the three assessments documented none were complete in their entirety and none concluded which plan was appropriate for R54 (i.e., bladder retraining, scheduled toileting or check and change program).</p> <p>The 10/06/11 "Bladder Assessment" inaccurately indicated the resident was incontinent of urine (multiple daily episodes of incontinence), unaware of bowel/bladder urges and had no urinary catheter in place. Physician's order to remove</p>	F 315		
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Dana Smith NHA 4-13-12

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 315	Continued From page 25 catheter was dated 10/11/12. Nurses note states urinary catheter was not removed until 10/12/11. There was no evidence of an assessment of bladder using the 3-day voiding diary or that a voiding program was in place to show that an attempt to improve bladder function was being attempted..	F 315			
F 327 SS=D	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, it was determined that the facility failed to ensure that one (R264) out of 51 sampled residents was provided with sufficient fluid intake to maintain proper hydration and health. The facility failed to monitor and analyze R264's fluid intake on a daily basis, thus, failing to reassess the current interventions and failed to implement new interventions. These failures resulted in the resident being admitted to the hospital where he was found to have abnormal laboratory values indicating acute renal failure. Findings included: R264 was readmitted to the facility on 3/7/12 with diagnoses including muscle weakness, gout, malignant lymphoma, hypertension, congestive heart failure (CHF), atril fibrillation, edema of bilateral lower extremities (BLL), diabetes mellitus type II (DM II), and chronic obstructive pulmonary disease (COPD), and chronic renal insufficiency.	F 327 F 327	1. R264's no longer resides in the facility (March 28, 2012). <i>4-25-12</i> 2. All resident that are placed on hydration monitoring have the potential to be affected by this deficient practice. <i>4-25-12</i> 3. During the daily morning meeting residents who are placed on Hydration Monitoring will be reviewed to monitor that the daily intake are totaled and compared to goal. The Unit Manager will update the residents care plan to reflect changes. (April 25, 2012).. <i>4-25-12</i> 4. The Registered Dietitian will conduct random audits of residents on hydration monitoring to review care plans for updated (Attachment 11) (April 25, 2012). (B) Audits will be reviewed by the QA committee until substantial compliance is achieved (April 25, 2012). <i>4-25-12</i>		

Diana Smiles NWA 4-13-12

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F 327	<p>Continued From page 26</p> <p>The readmission blood work at the facility dated 3/7/12 indicated that the resident's blood urea nitrogen (BUN) level was elevated at 28 (normal range 10-26 mg /dl) and that the creatinine (creat.) level was elevated at 2.4 (normal range 0.5-1.5 mg/dl). In addition, the sodium level was within normal at 142 (normal range 135-145 mmol/L). BUN, creatinine, and sodium levels are indicators of fluid imbalance and renal function. On this laboratory document, the attending physician noted that the elevated creatinine result was "chronic."</p> <p>R264's "Nutrition Risk Assessment" dated 3/7/12 completed by E35 (Registered Dietician) documented R264's estimated fluid requirement of 1,400 cc (cubic centimeters) per day. In addition, the resident was assessed at risk for nutritional issues due to CHF edema of BLL, DM II, COPD, and fluid restriction.</p> <p>The resident's care plan for "risk of fluid output exceeding intake related to diuretic use" included a goal that the resident will not present with signs of dehydration X 90 days and included the following approaches:</p> <ul style="list-style-type: none"> - encourage fluid consumption and to monitor adequate fluid intake. - monitor resident for signs of dehydration (tenting skin, dry mouth, etc.) - monitor lab work per orders - monitor level of consciousness changes. <p>Review of attending physician's order dated 3/12/12 timed 5 PM documented " BMP (basic metabolic panel- blood test that measures your glucose level, and fluid balance, and kidney</p>	F 327		
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Diana Smiles NHA 4-13-12

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F 327

Continued From page 27

function) AM/CBC (complete blood count-blood test that calculates the cellular elements of the blood) in AM. Decrease metoprolol (medication for the management of hypertension) to 12.5 mg. (milligram) po twice daily, hold SBP (systolic blood pressure) < (less than) 110, HR (heart rate) < 55. Hold fluid restriction X 48 hours. "

E35's progress note dated 3/13/12 and timed 12:12 PM documented that "Pt's (patient's) fluid restriction has been hold as of 3/12." Review of the Nurse Practitioner's (E36) progress note dated 3/13/12 noted R264 with complaints of being "tired."

The repeat blood work dated 3/13/12 PM documented that the resident's BUN and creat. worsened to 45 mg /dl and 3.7 mg/dl respectively. In addition, the sodium level was within normal at 136 mmol/L.

A new order dated 3/13/12 documented "Vancomycin (antibiotic) 125 mg. QID (four times a day) x 1 week then 125 mg. po bid (twice a day) X1 week then 125 mg. daily X1 week then 125 mg. QOD (every other day) X 1 week then Vancomycin 125 mg. every third day X 1 week then D/C (discontinue)." An additional verbal physician's order dated 3/13/12 timed 4:46 PM was obtained by E4 (RN Unit Manager) documented " Isolation precaution-C. Diff. (clostridium difficile) Hydration monitoring X 5 days. "

Although hydration monitoring (HM) was ordered on 3/13/12, this new intervention was not added to the above care plan.

F 327

David J. ... WAK 4-13-12

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F 327

Continued From page 28.

An interview with E4 on 3/22/12 at approximately 11:30 AM revealed that the above order for HM was ordered in response to the elevated BUN on 3/13/12. E4 confirmed that the above care plan did not include the intervention for HM, however, E4 related that she did not feel that this new intervention needed to be included in the care plan.

Review of the "24 hours report" for 3/13/12 for the evening shift documented "positive for C. Diff, HM X 5D (days) ..."

Review of facility's Nursing Policy titled "Guideline: Hydration Monitoring" documented that the hydration monitoring form will be utilized for tracking residents who need to have their daily fluids needs tracked.

Review of the "Hydration Monitor" form revealed that there was no information for 3/13/12 and for 3/14/12 and 3/15/12, the facility failed to total the 24 hours fluids taken by the resident on this form. After adding the fluids documented on this form during the survey, the resident consumed the following which are well below the 1,400 cc per day requirement:
3/14/12-total of 750 cc
3/15/12-total of 1270 cc

An interview with E3 (Director of Nursing/DON) on 3/22/12 at 2 PM revealed when a resident is on HM, it is the facility's expectation that the evening shift total all the oral intake during the 24 hours period of time. In addition, that the care plan should reflect the new intervention of HM.

Review of hospital records dated 3/16/12

F 327

Deborah ... 4-13-12

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F 327	Continued From page 29 documented abnormal high BUN of 59 and critically high creatinine of 6.56. The hospital discharge summary dated 3/21/12 documented under "hospital course" that the resident received intravenous fluids for three days without improvement of BUN and creat. The IV fluids were stopped due to concerns of the patient developing CHF and nephrology was consulted." Principle diagnosis was documented at "acute renal failure, progressing." R264 was readmitted to the facility on 3/21/12. Record review lacked evidence that the facility tracked and monitored the R264's fluid intake, via the hydration monitoring document beginning on the 3-11 shift on 3/13/12 through the time he was sent to the hospital on 3/16/12.	F 327		
F 329 SS=D	483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 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. 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	F 329	<p>F329 Example 1</p> <ol style="list-style-type: none"> 1. R 143 now has a behavior monitoring sheet that includes side effects (April 13, 2012). 4-25-12 2. (A) All residents that have psychoactive medications ordered have the potential to be affected by this deficient practice. (B) The D.O.N./designee will do a full house sweep on residents that are on psychoactive medications to monitor for behavior sheets that include side effects. Corrective action will be taken accordingly (April 25, 2012). 4-25-12 3. The facility has initiated new behavior sheets that include side effects. The Staff Educator will educate nursing staff on the behavior flow sheets (April 25, 2012). 4-25-12 4. The D.O.N./designee will conduct random audits of residents that are on psychoactive medications to monitor for behavior sheets that include side effects (Attachment 12) (April 25, 2012). (B) Audits will be 4-25-12 	

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F 329	<p>Continued From page 30 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 interviews it was determined that for two out of 51 sampled residents, the facility failed to ensure that the resident's drug regimen was adequately monitored. Findings include:</p> <p>1. R143 had diagnoses including hemiplegia, acute kidney failure, post traumatic stress syndrome (PTSD), depression and dementia. Review of R143 medication administration record (MAR) noted that he was administered klonopin (an antipsychotic medication) 0.5mg (milligrams) twice daily for increased exit seeking and zyprexa 5 mg daily (antipsychotic) for PTSD.</p> <p>Review of the electronic Behavior Monthly Flowsheet (utilized by licensed nursing staff to monitor behavior symptoms including the target behavior, number of episodes and pharmacological and non-pharmacological interventions) from December 2011 to March 2012 listed behaviors and interventions but no notation for side effects. R143's care plan for "use of psychotropic medication" noted under interventions: "monitor/record/report to MD (physician) prn (as needed) side effects and adverse reactions of psychoactive medications (examples listed)."</p>	F 329	<p>reviewed by the QA committee until substantial compliance is achieved (April 25, 2012).</p> <p>F329 Example 2</p> <ol style="list-style-type: none"> R293 now has a behavior monitoring sheet that defines targeted behaviors in addition to side effects (April 13, 2012). (A) All residents that have psychoactive medications ordered have the potential to be affected by this deficient practice. (B) The D.O.N./designee will do a full house sweep on resident that are on psychoactive medications to monitor for behavior sheets that include side effects. Corrective action will be taken accordingly (April 25, 2012). The facility has changed to a behavior sheet that includes side effects. The Staff Educator will educate nursing staff on how complete the sheets to include targeted behaviors and side effects (April 25, 2012). The D.O.N./designee will conduct random audits of residents that are on psychoactive medications to monitor for behavior sheets that include side effects and targeted behaviors. (B) Audits will be reviewed by the QA committee until substantial compliance is achieved (April 25, 2012). 	<p>4-25-12</p> <p>4-25-12</p> <p>4-25-12</p> <p>4-25-12</p>
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Diana Smiles NHA 4-13-12

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F 329	<p>Continued From page 31</p> <p>Upon interview with E28 medication nurse, on 3/22/12 At 10:05 AM, concerning the flowsheet revealed he did not know why there was no side effects page.</p> <p>Findings were reviewed with E29, unit manager at 12:10 PM and confirmed that there was no evidence of ongoing side effect monitoring.</p> <p>2. R293 had an order for Xanax (medication to treat anxiety) 0.5 mg. (milligram) po (by mouth) TID (three times a day) PRN (as needed) for anxiety on 3/10/12 and review of the electronic Medication Administration Record (eMAR) documented that R293 was administered Xanax 0.5 mg. by mouth on the following dates and times:</p> <ul style="list-style-type: none"> - 3/12/12 at 12:32 PM - 3/12/12 at 8:45 PM - 3/13/12 at 1:21 PM - 3/17/12 at 10:39 AM - 3/18/12 at 6:10 AM <p>Record review lacked evidence that the facility defined and monitored the targeted behavior symptom for which Xanax was ordered and administered on the above dates and times. Additionally, there was no evidence of side effect monitoring for the use of Xanax.</p> <p>An interview with E4 (RN Unit Manager) and E37 (Corporate Clinical Liaison) on 3/22/12 at approximately 1 PM confirmed that the facility utilized the Behavior Monitoring Flow Record to document the monitoring of the targeted behavior in the eMAR system, however, the facility failed to</p>	F 329		
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F 329 Continued From page 32
initiate this for R293. In addition, E37 indicated that the monitoring of the side effects would be completed in the eMAR system, however, the facility staff was not aware of the electronic monitoring form and that the plan was to educate the staff of this use.

F 329

F 371
SS=E 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY

F 371

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

- F371**
Example 1 and 2
1. Once informed by the surveyor the two steam pans and the two scoops were cleaned and food debris was removed (3/12/12). *4-25-12*
 2. All residents have the potential to be affected by this deficient practice. *4-25-12*
 3. The Registered Dietitian and Food Service will conduct monthly kitchen inspections that will includes checking steam pans and scoops for food debris (April 25, 2012). *4-25-12*
 4. The results of the kitchen inspections will be reviewed by the QA committee until substantial compliance is achieved (Attachment 15) (April 25, 2012). *4-25-12*

This REQUIREMENT is not met as evidenced by:
Based on observations made in the kitchen while on tour with the food services director and in the Fenwick Unit main dining room, it was determined that the facility failed to store clean ware and utensils under sanitary conditions and handle food in a sanitary manner. Additionally, the facility failed to ensure proper technique was utilized in feeding four residents (R12, R48, R94, and R111). Findings include:

- F371**
Example 3 and 4
1. Certified Nursing Assistants will be educated on proper food handling (April 25, 2012). *4-25-12*
 2. All residents have the potential to be affected by this deficient practice. *4-25-12*
 3. The Staff Educator will educate Certified Nursing Assistants on the use of a proper barrier while handling food and not to touch food directly. *4-25-12*
 4. (A) The Food Service Director/designee will conduct random audits of food handling by C.N.A.'s in the dining room (Attachment 14) (April 25, 2012). (B) Audits will be reviewed by the QA committee until substantial compliance is achieved (April 25, 2012). *4-25-12*

1. In the kitchen On 03/12/12, two (2) out of seven (7) steam table pans stored on the clean pots and pans shelf had food debris on the food contact surfaces.
2. In the kitchen On 03/12/12, two (2) out of six

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F 371 Continued From page 33
(6) food scoops (one large and one small) in the clean utensils drawer had food debris on the food contact surfaces.

3. During lunch observation in the Fenwick dayroom on 3/12/12, the following occurred;
At 12:15 PM, a CNA, E27 pulled the bread out of wax paper with her bare hands for R12 to eat.
At 12:17 PM, E27 went to assist R48 and buttered her bread with bare hands.
At 12:24 PM, E27 pulled the bread out of the wax paper with her bare hands for R94. E27 did not perform any hand washing or sanitization between residents.

4. During the lunch observation in the Fenwick dayroom on 3/19/12 at 12:35 PM, a CNA, E31 picked up a buttered bread with her bare hands for R111 and put it on her tray.

Findings were reviewed with E1, Administrator, and E3, DON, on 3/23/12 at approximately 10:30 AM.

F 371

F 411 SS=D 483.55(a) ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS

The facility must assist residents in obtaining routine and 24-hour emergency dental care.

A facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; may charge a Medicare resident an additional amount for routine and emergency dental services; must if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and promptly refer

F 411

- F411
1. R207 was provided with information on how replace his dentures (March 30, 2012) 4-25-12
 2. All residents with dentures have the potential to be affected by this deficient practice. 4-25-12
 3. The Nursing Home Administrator will devise and maintain a list from outside resources for routine and emergency dental services (April 25, 2012). 4-25-12
 4. The maintenance of this list will be reviewed in the facility QA committee until substantial compliance is achieved (Attachment 13) (April 25, 2012). 4-25-12

Debra Innes, NHA 4-13-12

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F 411	<p>Continued From page 34</p> <p>residents with lost or damaged dentures to a dentist.</p> <p>This REQUIREMENT is not met as evidenced by: Based on clinical record review, review of the facility's policy and procedures, observation and interview it was determined that the facility failed to assist one (R207) out of 51 sampled residents with dental services after he reported his upper dentures were lost and needed to be replaced. Findings include: The facility's policy and procedures stated for Dental Services "...6. Residents with lost or damaged dentures will be promptly referred to a dentist after resident/next of kin is consulted". Cross refer F166 R207 was admitted to the facility on 2/27/12 with upper dentures. On 3/6/12 R207 complained to the facility he was missing his upper dentures. A Resident Concern form was filled out for this incident. On 3/13/12 at 10:44 AM R207 stated his dentures were missing and he wanted them replaced. R207 stated the facility stated it was his fault they were missing. R207 continued to state he did not care who's fault it was or who was going to pay for them he just wanted his dentures replaced. Review of R207's concern with E8 (LPN) on 3/19/12 at 9:42 AM revealed that she filled out a concern sheet about R207's missing teeth and gave it to the unit manager.</p>	F 411	<p>F441</p> <ol style="list-style-type: none"> All Certified Nursing Assistants will be instructed on the proper procedure for washing hands (April 25, 2012). <i>4-25-12</i> All residents have the potential to be affected by this deficient practice. <i>4-25-12</i> The Staff Educator/designee will educate licensed Nursing Staff and Certified Nursing Assistants on the proper procedure for washing hands (April 25, 2012). <i>4-25-12</i> (A) The D.O.N./designee will conduct random audits of Nursing Staff and Certified Nursing Assistant washing hands to monitor for proper technique. (B) Audits will be reviewed by the QA committee until substantial compliance is achieved (April 25, 2012). <i>4-25-12</i> 	
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F 411 Continued From page 35

An interview with E2 (Administrator) on 3/19/12 at 1:20 PM revealed she did not find out about R207's missing dentures until today. E2 confirmed this concern should have been sent to her immediately so dental services could be arranged for R207's in order to replace his upper dentures.

F 411

F 441 SS=E 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS

The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

(a) Infection Control Program
The facility must establish an Infection Control Program under which it -
(1) Investigates, controls, and prevents infections in the facility;
(2) Decides what procedures, such as isolation, should be applied to an individual resident; and
(3) Maintains a record of incidents and corrective actions related to infections.

(b) Preventing Spread of Infection
(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.
(3) The facility must require staff to wash their hands after each direct resident contact for which

F 441

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F 441	<p>Continued From page 36 hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and review of the facility's policy and procedures it was determined that the facility failed use proper hand washing techniques during the lunch observation on 3/12/12. Findings include:</p> <p>The facility's policy and procedures for Hand Washing stated "...6. Dry hands well with paper towel. 7. Turn off the faucet with a clean paper towel".</p> <p>On 3/12/12 during the lunch observation on the Fenwick unit the following staff members were observed washing their hands and turning the faucet off with their clean hands instead of a paper towel.</p> <p>-11:50 AM E25 (CNA) -11:55 AM E13 (CNA) -11:56 AM and 11:59 AM E23 (Activity Aid) -12:06 AM E24 (Hospice CNA) -12:15 PM E26 (CNA)</p> <p>The observations were reviewed with the E1 (Administrator), E3 (DON), and E39 (ADON) on 3/23/12 at 10:45 AM.</p>	F 441		

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F 497 SS=E	<p>483.75(e)(8) NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE</p> <p>The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and for nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.</p> <p>This REQUIREMENT is not met as evidenced by: Based on review of the facility's documents and interview it was determined that the facility failed to ensure 8 out of 11 CNAs sampled received the necessary training to ensure they had 12 CEUs annually that should have been identified during the CNAs performance reviews. Findings include: A sample of 11 CNAs were pulled to review their annual education. Of the 11 CNAs sampled 8 (E10, E11, E12, E13, E14, E15, E16 and E17) CNAs had 6.5 hours of training instead of the 12 hours required. Review of the information with E6 (RN staff educator) on 3/21/12 at 2:35 PM confirmed the facility failed to provide continuing education for the 8 CNAs.</p>	F 497	<p>F497</p> <ol style="list-style-type: none"> 1. Training hours will be added to the Certified Nursing Assistance annual performance review (April 25, 2012). <i>4-25-12</i> 2. All residents have the potential to be affected by this deficient practice. <i>4-25-12</i> 3. The facility will include the annual training hours earned on the Certified Nursing Assistance annual performance review (April 25, 2012). <i>4-25-12</i> 4. (A) The Human Resource Director will audit annual performance reviews to monitor for the required 12 hour per year in-service (Attachment 2) (April 25, 2012). (B) Audits will be reviewed by the QA committee until substantial compliance is achieved (April 25, 2012). <i>4-25-12</i> 	

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NAME OF PROVIDER OR SUPPLIER CADIA REHABILITATION - RENAISSANCE	STREET ADDRESS, CITY, STATE, ZIP CODE 26002 JOHN J WILLIAMS HIGHWAY MILLSBORO, DE 19966
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 497	Continued From page 38	F 497		
F 514 SS=D	<p>483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCESSIBLE</p> <p>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.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (1) resident, R112, out of fifty-one (51) residents sampled the facility failed to have complete clinical records. The facility failed to have a discharge order signed by the physician. Findings include:</p> <p>1. Although there was a Nurse Practitioner progress note on 12/27/11 that documented the plans to transfer the resident to another facility there no evidence of a physician's discharge</p>	F 514	<ol style="list-style-type: none"> R112 no longer resides in the facility (December 28, 2012). All residents that are being transferred to another facility have the potential to be affected by this deficient practice. The Staff Educator will educate the licensed nursing staff on the need to obtain a discharge order for residents being discharged to other facilities (A) The D.O.N./designee will conduct random audits on residents that have been discharged from the facility to monitor for a discharge order on residents that have been transferred to other centers (Attachment 7) (April 25, 2012). (B) Audits will be reviewed by the QA committee until substantial compliance is achieved (April 25, 2012). 	<p>4-25-12</p> <p>4-25-12</p> <p>4-25-12</p> <p>4-25-12</p>

Debra Smiles, NHA 4-13-12

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

PRINTED: 04/10/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085052	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/23/2012
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NAME OF PROVIDER OR SUPPLIER

CADIA REHABILITATION - RENAISSANCE

STREET ADDRESS, CITY, STATE, ZIP CODE
26002 JOHN J WILLIAMS HIGHWAY
MILLSBORO, DE 19966

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F 514	Continued From page 39 order. This was confirmed by interview with E3 (Director of Nursing) on 3/20/12. R112 was discharged to another long-term care facility on 12/28/11.	F 514		

W. Dea Smith LNA 4-13-12



DELAWARE HEALTH AND SOCIAL SERVICES

Division of Long Term Care
Residents Protection

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

STATE SURVEY REPORT

Page 1 of 2

NAME OF FACILITY: Cadia Rehabilitation – Renaissance

DATE SURVEY COMPLETED: March 23, 2012

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
<p>3201</p> <p>3201.1</p> <p>3201.1.2</p>	<p>An unannounced annual and complaint survey was conducted at this facility from March 12, 2012 through March 23, 2012. 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 116. The Stage 2 sample totaled 51 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>Refer to Plan of Correction on CMS 2567 report dated March 23, 2012 for:</p> <ul style="list-style-type: none"> F166 F225 F226 F241 F248 F279 F280 F309 F312 F315 F327 F329 F371 F411 F441 F497 F514 <p style="text-align: right;">4-25-12</p>
	<p>This requirement is not met as evidenced by:</p> <p>Cross refer to the CMS 2567-L survey report dated 3/23/12, F166, F225, F226,</p>	

Director's Signature [Signature] Title NHA Date 4-13-12



DELAWARE HEALTH AND SOCIAL SERVICES

Division of Long Term Care
Residents Protection

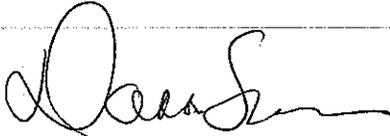
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STATE SURVEY REPORT

Page 2 of 2

NAME OF FACILITY: Cadia Rehabilitation - Renaissance

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SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	F241, F248, F279, F280, F309, F312, F315, F327, F329, F371, F411, F441, F497 & F514.	 N/A 4-13-12