DELAWARE HEALTH AND SOCIAL SERVICES

Division of Health Care Quality

Office of Long Term Care Residents Protection

DHSS - DHCQ
263 Chapman Road, Ste 200, Cambridge Bldg.
Newark, Delaware 19702
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: Delmar Nursing & Rehabilitation Center **DATE SURVEY COMPLETED: March 16, 2022**

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report.		
	An unannounced Annual, Complaint and Emergency Preparedness survey was conducted at this facility from March 9, 2022 through March 16, 2022. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census on the first day of the survey was 63. The survey sample totaled 26 residents.		
3201	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.0	**Scope**		
3201.1.2	**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.**		
	This requirement is not met as evidenced by:		
	Cross Refer to the CMS 2567-L survey completed March 10, 2022: Cross Refer to the CMS 2567-L survey completed March 16, 2022: F568, F578, F584, F655, F657, F686, F697, F732,		

Provider's Signature ___ Title Administrator Date 3/31/2022

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	F756, F812 and F943.		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085041	A. BUILDING ______ B. WING ______	C 03/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR NURSING & REHABILITATION CENTER	**101 DELAWARE AVE., DELMAR, DE. 19940-1110 DELMAR, DE 19940**

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted at this facility beginning March 9, 2022 through March 16, 2022, by the State of Delaware Division of Health Care Quality, Office of Long Term Care Residents Protection in accordance with 42 CFR 483.73. The facility census on the first day of the survey was 63. For the Emergency Preparedness survey, all contracts, operation plans, contact information, and annual emergency drills were up to date. No deficiencies were identified.	E 000		
F 000	INITIAL COMMENTS An unannounced Annual, Complaint and Emergency Preparedness survey was conducted at this facility from March 9, 2022 through March 16, 2022. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census on the first day of the survey was 63. The survey sample totaled 26 residents. Abbreviations and Definitions used in Survey: ADON - Assistant Director of Nursing; BOM - Business Office Manager; CNA - Certified Nursing Assistant; DON - Director of Nursing; LPN - Licensed Practical Nurse; MD - Medical Doctor; NHA - Nursing Home Administrator; OT - Occupational therapist; PT - Physical Therapist; RN - Registered Nurse; UM - Unit Manager;	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/06/2022

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F 000	Continued From page 1 Activities of daily living (ADLs) - tasks needed for daily living, e.g. dressing, hygiene, eating, toileting, bathing; ADL Self-Performance: - Extensive Assistance - resident involved in activity, staff provide weight-bearing support; - Limited Assistance - resident highly involved in activity, staff provide guided movement of limbs or other non-weight bearing assistance; - Total Dependence - full staff performance every time activity performed; Advance Directive - a statement of a persons wishes Biofreeze - can be applied to the skin for joint and muscle pain; BIMS (Brief Interview for Mental Status) - test to measure thinking ability with score ranges from 0 -15. 13-15: Cognitively Intact 8-12 Moderately Impaired 0-7 Severe Impairment; Braden Scale - test used to determine risk for developing pressure ulcers (score 15-18 is at risk; score 14 and under is high risk); DNR/DNI - Do Not Resuscitate, Do Not Intubate; Interdisciplinary Team - an approach that involves all disciplines to collaborate healthcare; Offloading/Offload - removal of pressure from an area (floating heels); POA (Power of Attorney) - person to act in your place for medical care and/or finances; PPM - Parts Per Million, a measurement to verify strength of solutions. Pressure ulcer - sore area of skin that develops when blood supply to it is cut off due to pressure; PRN - as needed; MAR (Medication Administration Record) - record of medication given to the resident, may be	F 000		

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F 000	Continued From page 2 electronic, (EMAR); MDS (Minimum Data Set) assessment - standardized assessment form used in nursing homes; mL-milliliter;	F 000		
F 568 SS=D	Accounting and Records of Personal Funds CFR(s): 483.10(f)(10)(iii) §483.10(f)(10)(iii) Accounting and Records. (A) The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. (B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. (C)The individual financial record must be available to the resident through quarterly statements and upon request. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to provide quarterly statements of personal funds accounts for one (R36) out of three residents reviewed for personal funds. Findings include: Undated - The facility policy entitled Patient/Resident Trust Account Policy and Procedure included that "Quarterly statements/reports must mailed/hand delivered to all residents/responsible parties. Proof that statements were sent quarterly must be kept at the facility." Review of R36's clinical record revealed the	F 568	Corrective Measures for residents affected: Resident R36 was provided a copy of the personal funds statement that was alleged to not be provided. Identification of others with the potential to be affected: All facility residents have the potential to be affected. Measures to prevent recurrence: Facility process changed to include proof of statement being mailed out and / or	4/23/22

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F 568	Continued From page 3 following: 1/9/15 - R36 was admitted to the facility. 10/28/21 - A quarterly MDS Assessment documented that R36 was cognitively intact. 3/9/22 9:48 AM - During an interview, R36 stated "I don't get a [personal funds] statement. I never get spending money." 3/14/22 1:45 PM - During an interview, E10 (BOM) showed R36 his statements and explained that the activities staff deliver these statements to him with the morning newsletters/mail. R36 confirmed he did not remember receiving them. R36 pointed to the balance (which was greater than $3,000) and said to E10 "I need to talk to you about this". When asked, R10 stated he does not know where to go to ask for spending money. E10 said she sets up hair cut appointments when she notices his hair has grown longer and bought him shorts in the past. R36 responded that he needs to buy pants. 3/16/22 2:50 PM - Findings were reviewed with E1 (NHA), E2 (DON), and E2 (ADON) during the exit conference.	F 568	handed to resident. All staff members responsible for the creation and distribution of the statement are to be educated. (Exhibit 1) Monitoring of corrective measures: Business Office Manager or designee will complete audits to ensure that quarterly statements are distributed. The audits will occur upon distribution of the statements until such time as 100% compliance is noted for three consecutive quarters. Audit results will be forwarded to the facility QAPI committee. (Exhibit 2)	
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive	F 578		4/23/22

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F 578	Continued From page 4 the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined that for two (R23 and R30) out of three residents reviewed for advance directives the facility failed to ensure residents were offered the choice to formulate an advance directive.	F 578	Corrective Measures for residents affected: Residents R23 and R30 were offered the choice to formulate an Advance Directives	

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F 578	Continued From page 5 Findings include: Undated - The facility policy for Advance Directives included "Prior to or upon admission to our facility, the Social Services Director, Admission Director or designee will provide written information to the resident concerning his/her right to make decisions concerning medical care, including right to accept or refuse medical or surgical treatment, and the right to formulate advance directives...The Interdisciplinary team will review annually with the resident his or her advance directives to ensure that such directives are still the wishes of the resident." 1. Review of R23's clinical record revealed: 6/5/20 - R23 was admitted to the facility. 6/5/20 - A Physician order revealed: Full code (CPR). 3/10/22 10:43 AM - During an interview, E7 (SW) confirmed the facility failed to provide information to R23 to make an informed decision to formulate an advance directive. During an interview on 3/14/22 around 1:15 PM, R23 confirmed that the facility failed to provide information in order for R23 to make an informed decision to formulate an advance directive. 2. Review of R30's clinical record revealed: 1/17/18 - R30 was admitted to the facility. 1/17/18 - A Physician order revealed: Do Not Resuscitate (DNR).	F 578	and provided with the required assistance. Identification of others with the potential to be affected: All facility residents have the potential to be affected. Measures to prevent recurrence: Managers are to be educated on need to offer residents, which are capable of making their own decisions, the choice of formulating Advance Directives during the admission process / assessment period and annually. (Exhibit 3) Monitoring of corrective measures: Social Worker or designee will complete an audit to ensure that all current residents, that are capable to formulate Advanced Directives, are approached and offered. (Exhibit 4) Monitoring audits for compliance will occur on the following schedule: Within 5 days of all new admissions until 100% compliance is noted for 10 consecutive new admissions and annual care plan review for 10 residents. Audit results will be forwarded to the facility QAPI committee. (Exhibit 5)	

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F 578	Continued From page 6 3/10/22 10:43 AM - During an interview, E7 (SW) confirmed the facility failed to provide information to R23 to make an informed decision to formulate advance directives. During an interview on 3/14/22 around 1:00 PM, R30 confirmed that the facility failed to provide information in order for R30 to make an informed decision to formulate an advance directive. 3/14/22 2:50 PM - During an interview, E5 (MD) confirmed that he does not discuss advance directives with residents. 3/16/22 2:50 PM - Findings were reviewed with E1 (NHA), E2 (DON), and E3 (ADON) during the exit conference.	F 578		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss	F 584		4/23/22

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F 584	Continued From page 7 or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that for one out of 14 resident rooms reviewed for environment, the facility failed to provide a safe, clean, comfortable, and homelike environment. Finding include: 3/9/22 8:29 AM - During an observation and interview of the bathroom in room 210, it was noted that to the right side of the toilet that the wall had a large deep hole in the plaster and paint approximately 6 inches in length by 10 inches in width and 2 inches deep. 3/9/22 8:35 AM - During an observation and interview, E14 (Laundry Services) confirmed the	F 584	Corrective Measures for residents affected: Damage to noted area was fixed immediately upon identification. Identification of others with the potential to be affected: All facility residents have the potential to be affected. Environmental Director or designee will complete an audit of facility residents to ensure that all resident areas are in compliance with guidelines. (Exhibit 6)	

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F 584	Continued From page 8 large gaping hole in the bathroom wall. 3/11/22 9:30 AM - During an interview, E9 (Environmental Manager) verbally confirmed the large hole was in the wall. 3/16/22 2:50 PM - Findings were reviewed with E10 (NHA), E2 (DON), and E2 (ADON) during the exit conference.	F 584	Measures to prevent recurrence: All staff to be educated on need to identify and report areas in resident area that are not promoting a safe, clean, comfortable, and home like environment for residents. (Exhibit 7) Monitoring of corrective measures: Environmental Director or designee will complete audits to ensure that that residents areas are safe, clean, comfortable, and homelike. The audits will occur on the following schedule: daily until 100% compliance is noted for five consecutive days, then three times a week until 100% compliance is noted for three consecutive weeks, then monthly until 100% compliance is noted for three consecutive months. Audit results will be forwarded to the facility QAPI committee. (Exhibit 8)	
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission.	F 655		4/23/22

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F 655	Continued From page 9 (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R317) out of one newly admitted resident reviewed, the facility failed to ensure that the baseline care plan was developed within 48 hours of the resident's admission that included initial goals, services, treatments,	F 655	Corrective Measures for residents affected: Resident 317 was provided information on their goals which was not noted on the Baseline Care Plan.	

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F 655	Continued From page 10 resident's medications and dietary instructions. Findings include: Record review for R317 revealed: 3/3/22 - R317 was admitted to the facility for rehabilitation. 3/4/22 - A baseline care plan was initiated for R317; however, no goals were established for: 1. Safety even though it was documented that he had a history of falling and was at risk of falls. 2. Therapy services even though it was documented that he will receive physical and occupational therapy at the facility. 3/15/22 12:50 PM - During an interview, E4 (UM, LPN) confirmed he completed R317's baseline care plan and that it did not contain initial goals for safety or therapy. 3/16/22 2:50 PM - Findings were reviewed with E1 (NHA), E2 (DON), and E2 (ADON) during the exit conference.	F 655	Identification of others with the potential to be affected: All new facility residents have the potential to be affected. Measures to prevent recurrence: Licensed Staff and Intra Disciplinary Team Members will be re-educated on the timeframe for completion, required areas for completion and review process with resident / Responsible Party. (Exhibit 9) Monitoring of corrective measures: Director of Nursing or designee will complete audits to ensure that all Baseline Care Plans are completed and reviewed. The audits will occur on all new admissions until 100% compliance is noted for 10 consecutive new admissions. Audit results will be forwarded to the facility QAPI committee. (Exhibit 10)	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident.	F 657		4/23/22

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F 657	Continued From page 11 (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that for one (R28) out of 26 residents reviewed for care plans, the facility failed to have the required members of the interdisciplinary care team included in developing the comprehensive care plan. Findings include: The facility Care Planning Policy (undated) included "Comprehensive care plan's will be completed by all members of the interdisciplinary team." 1. Review of R28's clinical record revealed: 12/2/21 - R28 was admitted to the facility. 12/15/21 - An MDS admission assessment documented R28's BIMS (Brief Interview for Mental Status) score was 10 (Moderately Impaired).	F 657	Corrective Measures for residents affected: Resident 28 has a care plan meeting scheduled. Identification of others with the potential to be affected: All facility residents have the potential to be affected. Measures to prevent recurrence: Managers to be educated on the need to ensure that newly admitted residents have an initial care plan meeting scheduled with 14 days of admission. (Exhibit 11) Monitoring of corrective measures:	

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F 657	Continued From page 12 12/17/21 - A Social Work note completed by E7 (SW) revealed that R28's POA was contacted regarding R28's adjustment to the facility, there was no evidence that a care plan meeting took place with R28's POA. 3/15/22 3:30 PM - A review of facility documentation lacked evidence that an interdisciplinary team met to complete R28's comprehensive care plan. A binder with care plan meeting attendance information provided by E7 did not include any documentation that any meetings had taken place for R28. 3/16/22 7:46 AM - In an interview, E7 (SW) revealed that the resident is due for a care plan meeting this month. When asked if R28 had the required care plan meeting on admission, she reviewed documentation and could not confirm that a comprehensive care plan meeting with members from the required disciplines had taken place. 3/16/22 8:12 AM - In an interview, E4 (NM) stated that the intial care plan meeting is usually done within 14 days of admission, when the admission MDS is complete. He also stated that R28 had been moved several times within the facility since entering because of behavior/health issues and confirmed a comprehensive care plan meeting for R28 may have been "missed". 3/16/22 2:50 PM - Findings were reviewed with E1 (NHA), E2 (DON), and E2 (ADON) during the exit conference.	F 657	Social Worker or designee will be responsible for auditing the compliance related to care plan meetings within 14 days of admission. The audits will occur on all new admissions until 100% compliance is noted for 10 consecutive new admissions. Audit results will be forwarded to the facility QAPI committee. (Exhibit 12)	
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)	F 686		4/23/22

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F 686	Continued From page 13 §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined that for one (R4) out of two residents reviewed for pressure ulcers the facility failed to ensure that a resident with a pressure ulcer received the care and services necessary to promote healing and prevent no sores from developing. Findings include: Review of R4's clinical record revealed: 9/6/18 - R4 was admitted to the facility. R4's care plan for skin included the following approaches: 9/6/18 - R4 was dependant for all ADL's and all care with two person assist. PT and or OT screening for change in position and mobility status. - Transfer using Hoyer lift with two person assist. - Turn and position every two hours with skin checks. Avoid pressure over bony prominences. - 1/2/19 - Float heels.	F 686	Corrective Measures for residents affected: Resident R4 interventions related to pressure areas were reviewed with Medical Director, Dietician, and Wound Care Consultant and any recommendations/orders were reviewed and implemented with resident transitioning to Hospice Care. A facility-wide sweep was conducted on all residents while simultaneously retraining Licensed Nurses and Nurse Aides on how to off-load and position heels, heel inspections for abnormalities, and reporting any alterations of skin integrity. Identification of others with the potential to be affected: All facility residents have the potential to be affected.	

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F 686	Continued From page 14 - 12/2/21 - Updated to float heels using pillows. 1/15/20 - R4's Braden scale (tool used to determine risk for development of pressure ulcers) score was eleven (10-12 is high risk). 12/2/21 - An annual MDS documented R28 has pressure ulcers and is totally dependent on two staff for bed mobility and transfer. 12/2/21 - 3/15/22 - Review of CNA documentation lacked evidence that the task of floating heels was added to alert CNAs of this new intervention. At the following dates and times, R4 was observed with the heels on the mattress and not floated: 3/11/22 10:53 AM; 3/14/22 8:29 AM, 10:35 AM, and 1:25 PM; 3/15/22 8:35 AM, 10:45 AM, 1:24 PM, and 4:05 PM; 3/16/22 8:02 AM and 12:25 PM. 2/28/22 - A wound assessment form documented a pressure ulcer to the left heel. 3/14/22 10:35 AM - During a dressing change with the facility contracted wound care nurse and E4 (LPN) it was observed that R4's heels were laying on the mattress. When dressing change was completed R4's heels were again laying on the mattress and not elevated. 3/15/22 4:08 PM - During an interview, E16 (CNA) stated R4 was a two person assist and totally dependant for all care. E16 also stated that if she had any questions or concerns about R4 she would ask the nurse. 3/15/22 4:12 PM - During an interview, E17	F 686	Measures to prevent recurrence: All Nursing Staff to be educated on the need to ensure that preventive measures related to pressure sores are followed and refusals or difficulties with adherence to plan of care are reported. (Exhibit 13) Monitoring of corrective measures: Assistant Director of Nursing or designee will complete audits on all high-risk resident for proper positioning of heels to prevent pressure ulcers, documentation of the preventive measures, and weekly skin assessments. The audits will occur on the following schedule: daily for 4 weeks until 100% compliance is achieved, then weekly for 3 months. Audit results will be forwarded to the facility QAPI committee. (Exhibit 14)	

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F 686	Continued From page 15	F 686		

(CNA) stated R4 was total care, re-position every two hours and she had a sore on her heel "I put a pillow or something under her feet." When asked where she documented that she replied "there's nowhere in our charting for that."

3/15/22 4:18 PM - During an interview, E15 (LPN) reported the unit manager is responsible for entering CNA tasks into the EMR so that they have a place to sign off resident care. [This is how CNA's would become aware and know to provide the care of floating the heels.]

3/16/22 8:05 AM - During an interview, E18 (CNA) stated R4 was a two person assist. "We turn her, check her skin, put a wedge to support her back and a pillow to elevate her heels." When asked where she documents, elevating the heels she did not know.

3/16/22 12:40 PM - During an interview and observation, E19 (CNA) was asked by this Surveyor to demonstrate how R4's heels are elevated. She placed a pillow under R4's lower legs but her heels were still laying on the mattress. E19 confirmed this and stated "it's difficult to keep her feet off the mattress because she's so contracted."

3/16/22 1:22 PM - During an interview, E3 (ADON) and E2 (DON) confirmed there was a lack of evidence that the CNAs were made aware of the approach to elevate R4's heels.

The facility failed to implement and monitor the intervention of floating heels for a resident with pressure ulcers.

3/16/22 2:50 PM - Findings were reviewed with

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F 686	Continued From page 16 E1 (NHA), E2 (DON), and E3 (ADON) during the exit conference.	F 686		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review, interview, and review of other facility documents, it was determined that for one (R33) out of two residents sampled for pain management the facility failed to provide pain management in accordance with standards of practice by not assessing pain intensity (severity) before and after PRN (as needed) pain medication. Findings include: 2002 - Pain management standards by the American Geriatrics Society included: appropriate assessment and management of pain; assessment in a way that facilitates regular reassessment and follow-up; same quantitative pain assessment scales should be used for initial and follow up assessment; set standards for monitoring and intervention; and collect data to monitor the effectiveness and appropriateness of pain management. June 2018 (last reviewed) - The facility policy entitled Pain Management Guideline revealed "...Functions of appropriate pain management include ...Assessing pain and evaluating response to pain management interventions	F 697	Corrective Measures for residents affected: The correct pain scale for indicating pain level prior and after pain medication administration has been added to resident 33's eMAR, including location of pain. Identification of others with the potential to be affected: All facility residents have the potential to be affected. Measures to prevent recurrence: All Licensed Nursing Staff to be educated on the Pain Management Policy to include physical monitoring for side effects, pain location, pain ratings and effectiveness of interventions. (Exhibit 15) Monitoring of corrective measures: Director of Nursing or designee will	4/23/22

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F 697	Continued From page 17 using a pain management scale based on patient / resident self-report...Documenting pain assessment and interventions prior to giving medication. Evaluation activities should be recorded in a concise manner per the plan of care. Nursing staff should utilize the electronic pain evaluation and nursing note link when it is available ...Numeric Rating Scale [0-10], Verbal Descriptor Scale [no pain is 0 through worst pain possible is 10] are utilized to screen and assess pain level ...". Review of R33's clinical record revealed the following: 7/18/19 - R33 was admitted to the facility. 7/19/21 - A care plan for pain was initiated with a goal that R33, "will maintain a pain level below [his] acceptable of 5/10 on a pain scale ...". 1/25/22 - A quarterly MDS Assessment documented that R33 was cognitively intact and independent with daily decision making. January 1 - March 15, 2022 - A review of the eMAR, assessments and nursing progress notes found that R33 received 17 doses of PRN pain medication: - 16 of the 17 administrations lacked an assessment of pain severity (pain scale) before the medication was given. - 16 of the 17 administrations lacked an assessment of pain severity after the medication was given. - 2 of the 17 administrations lacked any assessment of the effectiveness of the pain medication.	F 697	complete audits to ensure that assessment, side effects, pain location, pain ratings and effectiveness of medication is completed. The audits will occur on the following schedule: daily until 100% compliance is noted for five consecutive days, then three times a week until 100% compliance is noted for four consecutive weeks, then monthly until 100% compliance is noted for three consecutive months. Audit results will be forwarded to the facility QAPI committee. (Exhibit 16)	

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F 697	Continued From page 18 - 12 of the 17 administrations lacked the location of the resident's pain. 3/16/22 8:30 AM - During an interview, R33's nurse (E24 LPN) demonstrated how the pain scale and location of pain should be documented in the eMAR. 3/16/22 2:50 PM - Findings were reviewed with E1 (NHA), E2, and E2 (ADON) during the exit conference.	F 697		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors.	F 732		4/23/22

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F 732	Continued From page 19 §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of facility documentation it was determined that the facility failed to ensure the daily staff postings were accurate, complete and posted in a prominent place. The facility failed to post and accurately calculate the total number and actual hours worked by Registered Nurses (RN), Licensed Practical Nurses (LPN), and/or Certified Nurse Assistants (CNA). Findings include: 3/10/22 9:09 AM - Facility staffing sheet posted on a board to the right of the reception desk facing Section one Nurses station and not in a prominent place accessible to residents and visitors. In addition the facility failed to post the hours physically worked by nurses and CNAs assigned to direct resident care as per the federal requirement. 3/10/22 9:11 AM - During an interview, E1 (NHA) confirmed the sheet did not include the calculations for the direct resident care staff and that the document was posted in a place that wasn't easily accessible to residents and visitors.	F 732	Corrective Measures for residents affected: Due to the nature of the issue, the facility cannot correct past records or practices. Measures to prevent recurrence: Managers and Scheduler to be educated on the need to post Nursing Staffing information that includes: facility name, current date, total number and actual hours worked by nursing staff and census. This information is to be posted in a readily accessible area for residents and visitors. (Exhibit 17) Monitoring of corrective measures: Admission Director or designee will complete audits to ensure that the Nursing Staffing information is posted with required information. The audits will occur on the following schedule: daily until 100% compliance is noted for five consecutive	

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F 732	Continued From page 20 3/11/22 9:18 AM - The staffing sheet was posted in the same place and missing the calculations for direct resident care staff. 3/16/22 (approximately 10:00 AM) - Review of facility daily staffing sheets that were posted for the duration of the survey did not include the calculations for direct resident care staff. 3/16/22 2:50 PM - Findings were reviewed with E1 (NHA), E2 (DON), and E3 (ADON) during the exit conference.	F 732	days, then three times a week until 100% compliance is noted for three consecutive weeks, then monthly until 100% compliance is noted for three consecutive months. Audit results will be forwarded to the facility QAPI committee. (Exhibit 18)	
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the	F 756		4/23/22

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F 756	Continued From page 21 resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined that for one (R23) out of five sampled residents, for medication regimen review the attending physician failed to act upon the irregularities reported by the licensed pharmacist. Findings include: September 2018 - The facility policy, Medication Regimen Review (MMR) and Reporting included that "The consultant pharmacist reviews the medication regimen and medical chart of each resident at least monthly to appropriately monitor the medication regimen and ensure that the medications each resident receives are clinically indicated...Recommendations shall be acted upon within thirty calendar days. For those issues that require physician intervention, the attending physician either accepts and acts upon the report and recommendations or rejects all or some of the report and should document his or her rationale of why the recommendation is rejected in the resident's medical record."	F 756	Corrective Measures for residents affected: Due to the nature of the issue, the facility cannot correct past records or practices. Identification of others with the potential to be affected: All facility residents have the potential to be affected. Measures to prevent recurrence: All Licensed Staff will be educated on the need to ensure that all medication recommendations are reviewed by Medical Director or designee and approved recommendations are taken. (Exhibit 19) Monitoring of corrective measures:	

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F 756	Continued From page 22 Review of R23's clinical record revealed: 5/10/21 - Consultant Pharmacist Recommendation to Physician: "PRN Biofreeze topical gel. This medication has not been utilized in the past sixty days. Please discontinue this medication and decrease the possibility of outdated drugs being stored in the nursing facility." No Physician response. 6/7/21 - Consultant Pharmacist Recommendation to Physician: "This resident has been taking Prilosec 40 mg QD [every day] since 6/5/20 for GERD [Gastroesophageal reflux disease - occurs when stomach acid or, occasionally, stomach content, flows back into your food pipe]. It is recommended to review the use after twelve weeks of therapy. Chronic therapy has been associated with many potential adverse side effects. If indicated can the Prilosec therapy be discontinued at this time? If therapy is still indicated maybe a decrease in dose would be of benefit?" No Physician response. 10/6/21 - Consultant Pharmacist Recommendation to Physician: "Current order for Flonase one spray in both nostrils twice a day since 5/11/21 for allergic rhinitis [a stuffy, runny nose]. Can the Flonase therapy be discontinued at this time? If therapy is to continue can the dose be decreased to one spray in each nostril every day, the recommended maintenance dose?" No physician response. 12/9/21 - Consultant Pharmacist Recommendation to Physician: "Resident is currently receiving Lactulose 60 ml three times a day and Miralax twice a day. Due to duplicate therapy can one of these medications be	F 756	Director of Nursing or designee will complete audits to ensure that that all medication recommendations are reviewed by Medical Director or designee and approved recommendations are taken. The audits will occur monthly, post Pharmacist review, until 100% compliance is noted for five consecutive months. Audit results will be forwarded to the facility QAPI committee. (Exhibit 20)	

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	085041	A. BUILDING ______ B. WING ______	C 03/16/2022

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DELMAR NURSING & REHABILITATION CENTER	101 DELAWARE AVE., DELMAR, DE. 19940-1110 DELMAR, DE 19940

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F 756	Continued From page 23 discontinued at this time? The Lactulose is administered for increased ammonia levels chronic viral hepatitis (the liver processes nutrients and filters blood. When the liver is inflamed or damaged it's function can be affected). Maybe the Miralax could be changed to as needed status at this time? No physician response. 3/15/22 2:25 PM - During an interview, E4 (LPN) confirmed that the irregularities reported by the pharmacist on 5/10/21, 6/7/21, 10/6/21 and 12/9/21 were not acted upon or acknowledged by the physician. 3/16/22 2:50 PM - Findings were reviewed with E1 (NHA), E2 (DON), and E3 (ADON) during the exit conference.	F 756		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and	F 812		4/23/22

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F 812	Continued From page 24 serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, and interview it was determined that the facility failed to ensure that food was stored, prepared, and served in a sanitary manner. Finding include: Facility Policy: Dietary Department "Infection Control Guidelines" (no date) states that staff in the kitchen are to wear hair nets or caps to ensure a healthy environment and minimize the risk of food born infections. Facility Policy : "Dietary Department Sanitizer Guidelines" (no date) states sanitizer solution is checked when the sanitizing bucket is refreshed and then every four hours during the shift. Audits are completed by the kitchen manager twice a week and through a sanitation audit completed by the supervisor once a week. 1. 3/9/22 8:10 AM - During the intial tour of the kitchen, the following observations were made: - Two packages of open grated cheese were noted in the walk in refridgerator were unlabeled. - Three large open bottles of ranch dressing were not labeled and one of these was not properly closed and had dressing on the lid. These observations were confirmed with E11 (cook). 2. 3/9/22 8:10 AM - E13 (Dietary Aide) was observed in the kitchen without a hairnet on. 3/9/22 1:00 PM - A random observation revealed that E13 (Dietary Aide) was not wearing a hairnet	F 812	Corrective Measures for residents affected: Due to the nature of the issue, the facility cannot correct past records or practices. Identification of others with the potential to be affected: All facility residents have the potential to be affected. Measures to prevent recurrence: All Dietary Staff to be educated on wearing of hair nets, labeling of food, cleanliness of food items, and monitoring of functioning of equipment, such as sanitizer solution distributor. (Exhibit 21) Monitoring of corrective measures: Dining Manager or designee will complete audits to ensure all hair nets are worn in designated areas, food is labeled, and equipment is being monitored for proper functioning. The audits will occur on the following schedule: daily until 100% compliance is noted for five consecutive days, then three times a week until 100% compliance is noted for three consecutive weeks, then monthly until 100% compliance is noted for three consecutive months. Audit results will be forwarded to the facility QAPI committee. (Exhibit 22)	

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F 812	Continued From page 25 in the kitchen. 3/9/22 2:15 PM - During an interview with E12 (Dietary Manager) confirmed that E13 (Dietary Aide) was not wearing a hairnet when observed after lunch. 3/9/22 3:42 PM - During an interview E12 confirmed that he would re-educate kitchen staff on the wearing of hair restraints in the kitchen. 3. 3/9/22 8:40 AM - During the kitchen tour, E13 (Dietary Aide) performed a test on the sanitizer bucket to determine strength of the sanitizer solution, she and the surveyor both saw the test strip read zero ppm (meaning the bucket did not have any sanitizer). A retest was performed with the same result. E13 then dumped the bucket and refilled it and retested the solution, which again read zero ppm. The surveyor observed that the tubing coming from the sanitizer liquid was not filled with sanitizer liquid. E13 stated she usually tests the solution when she starts work and then at least one more time during the shift. 3/9/22 9:00 AM - In an interview E12 (Dietary Manager) confirmed that the sanitizer was not flowing into the line. He stated that this system was working on 3/8/22. E12 then called E9 (Environmental Manager) to look at the system and repair it. 3/9/22 10:10 AM - In an interview E12 (Dietary Manager) stated the staff will use spray sanitizing solution until the sanitizer system is repaired. 3/9/22 12:45 PM - A random observation confirmed that the sanitizing solution was now flowing into the tubing and delivered into the	F 812		

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F 812	Continued From page 26 bucket as designed. 3/9/22 3:42 PM - In an interview E12 (Dietary Manager) provided auditing process policy of sanitizing solution concentrations. E12 provided logs for the past two months (January and February) which confirmed audits were completed. E12 also confirmed that staff tested the sanitizing solution anytime the bucket is refreshed and every four hours. 3/16/22 2:50 PM - Findings were reviewed with E1 (NHA), E2 (DON), and E2 (ADON) during the exit conference.	F 812		
F 943 SS=D	Abuse, Neglect, and Exploitation Training CFR(s): 483.95(c)(1)-(3) §483.95(c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- §483.95(c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. §483.95(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property §483.95(c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on interview and review of facility documentation it was determined that the facility failed to ensure the required training of Abuse,	F 943	Corrective Measures for residents affected:	4/23/22

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F 943	Continued From page 27 Neglect, and Exploitation Training was completed for two (E28 and E29) out of twelve randomly selected staff members. Findings include: December 2021 (last revised) - The facility's policy entitled "Abuse, Neglect, Mistreatment and Misappropriation of Resident Property" included: "It is the policy of this facility to train employees, through orientation and on-going sessions on issues related to abuse and prohibition practices." Review of the documented completion of required abuse, neglect ,and exploitation revealed no evidence of the training being completed for the following two staff members: - E28 (OT): hire date 12/31/20 - E29 (PTA): hire date 3/1/21 3/14/22 9:55 AM - During an interview, E31 (Educator) confirmed the absence of tracing for the staff members listed above. No further evidence of training was provided. 3/16/22 2:50 PM - Findings were reviewed with E1 (NHA), E2 (DON), and E3 (ADON) during the exit conference.	F 943	Contracted therapy staff noted to need the education will complete training. Identification of others with the potential to be affected: Nurse Educator or designee will complete an audit to ensure that all staff and other required to have education have completed education on facility Abuse Policy within the last 12 months. (Exhibit 23) Any staff identified as needing the education will be provided education. Measures to prevent recurrence: Nurse Educator and Managers to be educated on the need for all staff and others designated vendors/consultants/contractors to complete Abuse Policy yearly. (Exhibit 24) Monitoring of corrective measures: Director of Nursing or designee will complete audits to ensure that yearly education on Abuse Policy is conducted. The audits will occur on the following schedule: 100% compliance is noted for all new hires and designated vendors/consultant's/contractors for 3 months. Audit results will be forwarded to the facility QAPI committee. (Exhibit 25)	