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: Churchman Village

DATE SURVEY COMPLETED: March 19, 2024

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 February 29, 2024, through March 19, 2024. The deficiencies contained in this report are based on observations, interviews and record reviews. The facility census on the first day of the survey was 90 residents. The survey sample size was 23.	Please cross reference CMS 2567poc submitted on 04/04/2024. Cross Refer to the CMS 2567-L survey completed March 19, 2024: F561, F582, F584, F610, F640, F641, F656, F657, F658, F660, F661, F689, F695, F756, F758, F803, F812, F842, F880, F940.	
3201	**Regulations for Skilled and Intermediate Care Facilities**	1. E17 now have their 2-step tuberculin test completed. 2. All residents have the potential to be affected. 3. The RCA was determined to be that facility failed to give the first step Tuberculin test before the first day of hire. The facility will now provide the first step. Tuberculin test before the first day of hire. The Staff Developer/designee will educate the HR Director, NHA, and DON on the new process. The HR Director/designee will audit 25% of new hires for compliance to completing the first step Tuberculin test before the first day of hire.	
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 19, 2024: F561, F582, F584, F610, F640, F641, F656, F657, F658, F660, F661, F689, F695, F756, F758, F803, F812, F842, F880, F940.		
3201.6.9.2	**Specific Requirements for Tuberculosis**		

Provider's Signature Rhonda Dawn Title NHA Date 4/11/24

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3201.6.9.2.4	**Minimum requirements for pre-employment tuberculosis (TB) testing require all employees to have a base line two step tuberculin skin test (TST) or single Interferon Gamma Release Assay (IGRA or TB blood test) such as QuantiFeron. Any required subsequent testing according to risk category shall be in accordance with the recommendations of the Centers for Disease Control and Prevention of the U.S. Department of Health and Human Services. Should the category of risk change, which is determined by the Division of Public Health, the facility shall comply with the recommendations of the Center for Disease Control for the appropriate risk category.** **This requirement was not met as evidenced by:** Based on interview, record review and review of other facility documentation, it was determined that for two (E15 and E 17) out of eight employees sampled, E15 and E17 pre-employment Tuberculin testing. Findings include: 1. 6/12/23 – E15 (cook) was hired. This was also the first day in the facility. The first step Tuberculin test was given on 6/26/23. Review of the facility's timecard showed E15 worked in the facility on 6/12/23. 2. 1/17/23 – E17 (Housekeeper) was hired. This was also the first day in the facility. The first step Tuberculin test was given on 1/17/23. Review of the facility's timecard showed E17 worked in the facility on 1/17/23. 3/5/24 3:00 PM – Findings were confirmed during an interview with E5 (Corporate Director of Human Resources).	4. Results of the audits will be reported in the monthly Quality Assurance and Assessment (QA&A) meetings until 100% compliance is achieved for three consecutive months and as needed.	

Provider's Signature [signature] Title NHA Date 4/11/24

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3201.9.0	**Records and Reports**		
3201.9.1	**There shall be a separate clinical record maintained on each resident as a chronological history of the resident's stay in the nursing facility. Each resident's record shall contain current and accurate information including the following:**	1. E41 (MD) was re-educated on regulation 3201.9.1.2. 2. All residents admitted to the facility have the potential to be affected. 3. The RCA was determined to be that E41 (MD) did not follow the regulation regarding history and physical being completed by a physician within 14 days of the resident's admission to the facility. The Staff Developer/designee re-educated on regulation 3201.9.2. on the requirement to complete a history and physical within 14 days of admission. The DON/designee will audit weekly 25% of admissions for timeliness of history and physical completed by the MD. 4. Results of the audits will be reported in the monthly Quality Assurance and Assessment (QA&A) meetings until 100% compliance is	
3201.9.1.2	**History and physical examination prepared by a physician within 14 days of the resident's admission to the nursing facility.** **This requirement was not met as evidenced by:** Based on record review and interviews, it was determined that the facility failed to ensure R106's admission History and Physical was completed by a physician within 14 days of R106's admission date. Findings include: R106's record revealed: 10/13/22 – R106 was admitted to the facility, with diagnoses, including but not limited to, fibromyalgia, diabetes, and sarcoidosis. 10/14/22 4:21 PM – E66 (PA), who was a Physician Assistant, saw R106 and documented a hospital record review and medication reconciliation. 10/18/22 8 PM – E66 (PA) documented a progress not in R106's EMR. 11/8/22 10:16 AM – E41 (MD) documented an encounter in R106's EMR. R106's first encounter with her Primary Physician in the facility for her admission History		

Provider's Signature Rhonda Reed Title NHA Date 4/11/24

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	and Physical occurred 26 days after her admission to the facility. 3/13/24 3:45 PM – Findings were reviewed with E1 (NHA), E2 (DON), E3 (Corporate Clinical Operations), E4 (Regional Clinical Specialist) and representatives from the Ombudsman office during the Exit Conference.	achieved for three consecutive months and as needed.	
3201. 9.5	**Incident reports, with adequate documentation, shall be completed for each incident. Adequate documentation shall consist of the name of the resident(s) involved; the date, time and place of the incident; a description of the incident; a list of the other parties involved, including witnesses; the nature of any injuries; resident outcome; and follow-up action, including notification of the resident's representative or family, attending physician and licensing or law enforcement authorities, when appropriate.** **This requirement was not met as evidenced by:** Based on record review and interview, the facility failed to complete an incident report for a 3/5/23 incident involving E54 (LPN), R98 and F2 (R98's representative). Findings include: 3/11/24 at 1:43 PM – During an interview, E56 (CNA) stated that she remembered the Sunday (3/5/23) incident and stated that E54 (LPN) and F2 were yelling and cussing at each other in the hallway outside R98's room. 3/11/24 at 2:30 PM – During an interview, E54 (LPN) remembered the incident from 3/5/23 about administering insulin to R98 and getting into an unpleasant verbal discussion with F2.	1. R98 no longer resides in the facility. 2. All residents whose representative gets into an unpleasant verbal discussion with an employee have the potential to be affected. 3. The facility failed to recognize the incident as an event that needs to be written on a grievance/incident report. The Staff Developer reeducated licensed staff and social workers on the need to document unpleasant verbal discussions with residents' representatives on a grievance/incident report. The Social Worker/designee will conduct weekly audits of grievances/incident reports to	

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	E54 acknowledged that she was out of line with her response to F2. When asked if she wrote a statement, E54 stated that she could not recall writing a statement. During the 3/13/24 annual and complaint survey, the Surveyor requested to review the facility's documentation regarding a 3/5/23 incident involving R98. The facility lacked evidence of a documented incident report/grievance from 3/5/23. 3/13/24 at 11:36 AM - During an interview, finding was reviewed with E1 (NHA), E2 (DON) and E3 (Corporate Clinical Operations). 3/13/24 at 3:45 PM - Finding was reviewed with E1, E2, E3, E4 (Regional Clinical Specialist) and representatives from the Ombudsman Office. No additional information was provided to the Surveyor.	monitor for grievance/incident forms on unpleasant verbal discussions. 4. Results of the audits will be reported in the monthly Quality Assurance and Assessment (QA&A) meetings until 100% compliance is achieved for three consecutive months and as needed.	

Provider's Signature [signature] Title NHA Date 4/11/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085025	A. BUILDING _____ B. WING _____	C 03/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHURCHMAN VILLAGE	4949 OGLETOWN-STANTON ROAD NEWARK, DE 19713

(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
E 000	Initial Comments An unannounced annual and complaint survey was conducted at this facility from February 29, 2024 through March 13, 2024. The facility census was 90 on the first day of the survey. In accordance with 42 CFR 483.73, an Emergency Preparedness survey was also conducted by The Division of Health Care Quality, the Office of Long-Term Care Residents Protection at this facility during the same time period. Based on interviews and document review, no Emergency Preparedness deficiencies were identified.	E 000		
F 000	INITIAL COMMENTS An unannounced Annual and Complaint survey was conducted at this facility starting on Febraury 29, 2024 and completed on March 19, 2024. The deficiencies contained in this report are based on observations, interviews and record reviews. The facility census on the first day of the survey was 90 residents. The survey sample size was 23. DEFINITIONS: anticoagulation - medication that prevents clots from forming; ataxia - poor muscle control that causes clumsy movements; BIMS - Basic Inventory of Mental Status; a structured assessment tool aimed at evaluating cognition in the elderly. BIMS score of 0-7 is reflective of severe cognition deficit, 8-12 reflects a moderate cognition deficit and 13-15 is reflective of normal cognition; CNA - Certified Nurses Aide; DHCQ - Delaware Health Care Quality/also known as the State Survey Agency;	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 04/11/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 DHIN - Delaware Health Information Network/electronic access to hospital records; DON - Director of Nursing; ESBL - "extended- spectrum beta lactamases"; enyzmes that confer resistance to most beta-lactam antibiotics, including penicllins, cephalosporins and the monobactam aztreonam; EMR - electronic medical record; Glucose meter/glucometer - a device for determining the approximate concentration of glucose in the blood; LPN - Licensed Practical Nurse; MDS - Minimum Data Set/federally mandated comprehensive, standardized, clinical assessment of all residents in Medicare/Medicaid nursing homes that evaluates functional capabilities and health needs; mg - milligram; ml - a unit of capacity equal to 1/1000 liter; NHA - Nursing Home Administrator; nephrostomy tube - small tube placed directly in the kidney in order to drain urine from the kidney; PCC - Point click care, the facility's electronic medical record application; PCI - percutaneous coronary intervention; more commony called a cardiac cath; PICC - peripheral intravenous central catheter; saline - sterile salt water with similar concentration to body fluids; sepsis - an infection that has spread to the blood stream resulting in a cluster of symptoms such as low blood pressure, increase in heart rate and fever.	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must	F 561		5/9/24

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F 561	Continued From page 2 promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f) (1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of facility documentation it was been determined that for three (R102, R346, R446) out of twenty-three residents reviewed for choices, the facility failed to ensure care preferences were being honored. Findings include: 1. Review of R346's clinical record revealed: 12/5/22 - R346 was admitted to the facility with diagnoses including stroke and aphasia (affects	F 561	1.*E18 was re-educated on resident rights. *R446's shower schedule was adjusted to her dialysis schedule. *Nursing is now being informed of R102's shower refusals. 2. *All residents have the potential to be affected. *All residents receiving dialysis had their shower schedules reviewed and adjusted	

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F 561	Continued From page 3 ability to communicate). 12/6/22 - Review of R346's care plan for communication problem related to aphasia revised 1/19/24 included interventions to allow adequate time to respond, repeat as necessary, do not rush, request clarification from the resident to ensure understanding, use simple brief words and cues. Other interventions included: resident is able to answer yes/no by nodding, points to things and is able to make needs know to staff at all times. 2/25/23 - Review of the facility's form for verification of investigation documented ... "1. Following investigation and interview of witness the assigned CNA (Certified Nursing Assistant) refused to honor the residents' rights to refuse and make choices ... 2. Instead, the CNA proceeded to force the resident to get changed." 2/27/23 Review of facility provided documentaton revealed: 2/27/23 - E2 (DON) interviewed E18 (CNA) and confirmed R346 was agitated (upset) when E18 was attempting to perform ADL care and personal hygiene. 2/27/23 - E2 interviewed E59 (CNA). During the interview E59 confirmed R346 was nodding "no and pointing" that the resident did not want care to be given by E18. 2/27/23 - E2 interviewed E60 (LPN). E60 heard screaming and yelling and walked into [R346's] room and asked what was wrong and said [R346] was gesturing to get E18 out of the room." E60 said E18 stated "[R346] ripped the first	F 561	as necessary. 3. *The RCA determined that staff failed to promote residents' rights for self-determination regarding care and services. *The Staff Developer/designee will re-educate C.N.A.'s and licensed staff on resident rights, including self-determination regarding care and services. *The DON/designee will audit 100% of residents on dialysis weekly for their shower schedules, comparing them to the assigned shower schedule for conflict. *The DON/designee will audit 50% of residents who refused showers weekly to monitor that the nurse was informed, and that residents who indicated a preference for another caregiver were given a choice. 4. *Results of the audits will be reported in the monthly Quality Assurance and Assessment (QA&A) meetings until 100% compliance is achieved for three consecutive months and PRN as indicated.	

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F 561	Continued From page 4	F 561		

diaper and now I am trying to put on a second one." E60 told E18 "you need to go".

3/12/24 10:38 AM - During a telephone interview E18 revealed "[R356] was frustrated about being cleaned up after the resident had a bowel movement." E18 said, "I told [R346] I could not leave her like that, she always refused care, she needed to be cleaned up." E18 said, "E59 told the nurse because she felt like I was being rough with [R346], and that I was making the resident do something that the resident did not want to be done." E18 stated, "the other girl said that the way I turned [R346] it was a push instead of a turn and hold the resident."

3/12/24 10:50 AM - During a telephone interview E59 said, "that happened almost a year ago." E18 asked me to help with changing the resident, when I went into the room [R346] pointed at me and I thought [R346] did not want me to help, but then [R346] pointed at E18, it's been a while, but I felt like E18 was pretty aggressive with changing [R346] and it upset me, and I reported it to E60."

3/12/24 12:27 PM - An interview with E2 revealed "[R346] did not want E18 to provide care and that E18 was insistent on getting [R346] changed and that E59 felt like it was [R346']s right to refuse care."

The facility failed to ensure that R346 was given the opportunity to exercise his/her rights of self-determination and choice of care giver and care and services provided.

2. Review of R446's clinical record revealed:

2/21/24 - R446 was admitted to the facility with

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F 561	Continued From page 5 diagnoses, including but not limited to, end-stage renal disease on hemodialysis. 2/21/24 - E52's (MD) order in R446's EMR stated, "Dialysis (Mon/Wed/Fri) at [hemodialysis center] Chair time 7:20 AM. Pick up time 6:00 - 6:30 AM." E52 also ordered, "Shower ...every evening shift every Saturday and every day shift every Wednesday." R446's care plan documented, "The resident needs dialysis: hemo r/t (related to) renal failure" with Interventions stating "Dialysis (Mon/Wed/Fri) at [hemodialysis facility]. Chair time 7:20 AM. Pick up 6:00 - 6:30 AM." 2/29/24 11:35 AM - During an interview, R446 stated that she has only been bathed one time since her admission on 2/21/24. 3/6/24 9:53 AM - During an interview, E30 (ADON) confirmed that R446 has hemodialysis scheduled on Monday, Wednesday and Friday day shift and that she typically returns after 4 PM. Surveyor reviewed nursing notes that documented R446's return time from her dialysis treatments Friday 2/23/24 at 4:32 PM, Monday 2/26/24 at 1:54 PM, Wednesday 2/28/24 at 5:17 PM and Friday 3/8/24 at 3 PM. 3/7/24 1:11 PM - During an interview, E30 (ADON) stated, "Showers are assigned by the room number that the resident is in. Of course, we can personalize it if the resident requests it." Surveyor reviewed the CNA Tasks tab in PCC and in the Bathing section, it was documented that R446 had "physical help in part of bathing	F 561		

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F 561	Continued From page 6	F 561		

activity" on Saturday, 2/24/24 at 9:59 PM and Saturday, 3/2/24 at 10:52 PM. The CNAs documented on Wednesday, 2/28/24 and Wednesday, 3/6/24 that "resident not available".

3. Review of R102's clinical record revealed:

12/31/22 - R102 was admitted to the facility with diagnoses including a left kneecap fracture. R102's showers were scheduled for Tuesdays 7-3, and Fridays 3-11 shift.

1/6/23 10:18 PM - R102's medical records documented, "RR, RR, RR - resident refused". R102's nursing progress notes lacked evidence that the nurse was informed of R102's refusal of the shower.

1/13/23 10:11 PM - R102's medical records documented, "NA, NA, NA - not applicable". R102's nursing progress notes lacked evidence that the nurse was informed that R102 did not receive a shower.

3/7/24 10:35 AM - During an interview R30 (ADON) confirmed that R102's medical records lacked evidence that the nurse was informed that R102 was given a shower. E30 stated, "The resident is supposed to be offered a shower three times, and the nurse should write a progress if she refused".

The facility failed to provide R102 a shower on 1/13/23, and lacked evidence that the nurse was notified that showers were not given on 1/6/23 and 1/13/23.

3/19/24 3:45 PM -Findings were reviewed with E1 (NHA), E2 (DON), E3 (Corporate Clinical

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F 561	Continued From page 7 Operations), E4 (Regional Clinical Specialist) and representatives from the Ombudsman Office.	F 561		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.	F 582		5/9/24

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CHURCHMAN VILLAGE	4949 OGLETOWN-STANTON ROAD NEWARK, DE 19713

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F 582	Continued From page 8 (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R96) of three residents reviewed for beneficiary notification, the facility failed to provide evidence that R96 or her responsible party was notified of Medicare non-coverage prior to her discharge on 12/20/23. Findings Include: Review of R96's clinical record revealed: 11/18/23 - R96 was admitted to the facility with diagnoses, including but not limited to, ataxia (poor muscle control that causes clumsy movements) and weakness. 11/25/23 - R96's admission Minimum Data Set (MDS) assessment documented a Brief Interview for Mental Status (BIMS) score of 11, which is reflective of moderate cognitive impairment.	F 582	1. *R96 no longer resides at the facility. 2. *All residents who require non-coverage notice may be affected. *The facility conducted a 90-day audit for non-coverage. *Results will be reported monthly in QA&A. 3. *The RCA found the facility lacked a system to track non-coverage notification deadlines. *A process was implemented during daily morning meetings to review residents needing non-coverage notices. *The Staff Developer /Designee will educate Social Workers, Therapy, Business Office, and MDS staff on the new process. *The Staff Social Worker/designee will	

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F 582	Continued From page 9 12/20/23 - R96 was discharged from the facility. 3/11/24 2:19 PM -During an interview, E1 (NHA) confirmed that the facility did not have a Notice of Medicare Non-Coverage (NOMNC) form for R96. 3/13/24 3:45 PM - Findings were reviewed with E1, E2 (DON), E3 (Corporate Clinical Operations), E4 (Regional Clinical Specialist) and representatives from the Ombudsman office.	F 582	audit 100% of resident's weekly who require a non-coverage notice. 4. *Audit results will be reported in monthly QA&A meetings until achieving 100% compliance for three consecutive months and PRN as indicated.	
F 584 SS=B	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 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;	F 584		5/9/24

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F 584	Continued From page 10 §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 two out of two shower rooms reviewed, the facility failed to provide services necessary to maintain a clean and sanitary environment. Findings include: 3/4/24 9:24 AM - During an observation of the East and West wings shower rooms, several large areas (where the walls met the tiles) of blackened substance were observed. Multiple areas of chipped and broken floor and wall tiles were also observed. 3/4/24 9:45 AM - During an environmental tour, it was observed that floors in rooms E101 through E122 were coated with a thick, blackened, greasy substance. An observation of rooms W101 through W122 revealed blackened, greasy substance on the floors as well. 3/5/24 11:00 AM - The shower rooms and the residents' rooms continued to have the same blackened substance on the walls, and the floors.	F 584	1.*Chipped tiles in shower rooms were repaired *Floors cleaned in E101 through E122. *The shower rooms were cleaned. 2. *All residents have the potential to be affected. 3.*The RCA determined that the facility lacked an adequate process for cleaning the shower room tiles or floors on a routine basis *The facility developed a new process for cleaning shower rooms and floors. *The Housekeeping Director/designee will educate housekeeping staff on the new process. *The Housekeeping Director will conduct weekly audits of 25% of the floors in the resident rooms for cleanliness. *The Housekeeping Director will conduct weekly audits of both shower rooms for cleanliness and check for chipped tiles.	

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F 584	Continued From page 11 3/5/24 1:30 PM - Findings were confirmed with E5 (Cooperate Resource Manager) and E6 (Maintenance/Housekeeping Director Findings were reviewed with E1 (NHA), E2 (DON), E3 (Corporate Clinical Operations), E4 (Regional Clinical Specialist) and representatives from the Ombudsman Office.	F 584	4.*Audit results will be reported in monthly QA&A meetings until achieving 100% compliance for three consecutive months and PRN as indicated.	
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R100) out of four residents reviewed for abuse, the facility failed to have evidence that R100's allegation of abuse was thoroughly investigated. Findings include:	F 610	1.*R100 no longer resides at the facility. 2.*All residents admitted to the hospital and alleging abuse through a 3rd party have the potential to be affected. *The facility conducted an audit of	5/9/24

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F 610	Continued From page 12 R100's clinical record revealed: 7/12/24 - R100's admission MDS assessment documented her BIMS as 13 (cognitively intact). 7/20/23 at 12:14 PM - R100 was sent to the hospital for an unrelated medical reason. 7/21/23 at 11:17 AM - The facility's incident report documented by E2 (DON) revealed the following: - "... an allegation of abuse; - Resident is in the hospital where incident of abuse was first reported. - Resident is oriented to self... time... place; - Resident was sent to the hospital... During conversation with the case worker, she reported an allegation of physical abuse by someone posing as an aide. She refused to reveal the name of the aide for fear of being killed. - Yes, police were notified." The facility provided the following additional investigative documents in response to R100's allegation of abuse: - 7/21/23 typed statement of the conversation between R100's family member and E2 (DON). - Transcribed and typed individual statements signed by 14 nursing staff who worked on R100's assignment from 7/16/23 through 7/20/23. - R100's progress notes from 7/15/23 through 7/24/23. - Abuse in-service sign-in sheets of nursing staff completed by E2 (DON) on 7/21/23. 7/28/23 at 5:04 PM (late entry as it was created 8/17/23 at 5:09 PM) - A nursing note, by E2 (DON), documented, "On 7/20/23, 2 Delaware State officers showed up in the facility and began to question staff about the resident who was	F 610	residents alleging abuse at the hospital in the past 90 days to validate a thorough investigation had been completed. *Further investigation was conducted as necessary. 3.*RCA identified that the facility lacked a system to address hospital abuse allegations being reported through a 3rd party. *VPO to educate senior leadership on investigating hospital abuse allegations and completing Verification of Investigation form. *NHA/designee to audit 100% of residents alleging hospital abuse for investigation thoroughness and form completion. 4.*Audit results will be reported in monthly QA&A meetings until achieving 100% compliance for three consecutive months. and PRN as indicated.	

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F 610	Continued From page 13 currently admitted in the hospital. The officers did not divulge why the staff was being questioned. DON on 7/21/23 reviewed the DHIN (Delaware Health Information Network) information and found in the medical record that the resident had made an allegation of physical abuse against staff at the facility. The hospital did not inform the facility of the allegation of physical abuse made by the resident while at the ER (emergency room). Initial report was sent to DHCQ (State Survey Agency) based on note found in the medical record at the hospital through DHIN... Interview of all other residents in the team assignment where resident (R100's initials) is included was completed. There was no verbalized concern of someone who has been physically aggressive with them when care was provided. Residents interviewed reported feeling safe in the facility. An interview of staff (nurses and nursing assistants) from 7/16/23 to 7/20/23 who took care of resident (R100's initials) was completed. There was not a verbalization of concern or complaint by the resident to any staff member of abuse. The resident did not complain to any staff member of being hurt at any time during care. An interview via phone with the resident's (family member) by DON of the allegation of abuse was completed... Resident's medical record in DHIN showed that resident refused examination by the Forensic nurse for a head-to-toe assessment and photographic documentation. Resident did not verbalize any concerns of abuse while in the facility to staff... Resident's allegation of abuse is unsubstantiated." Despite learning about the allegation of abuse after the State Police visit and reviewing R100's hospital documentation through DHIN, the	F 610		

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F 610	Continued From page 14 facility's investigation lacked documented evidence of: - attempts to interview R100 in the hospital and the hospital nursing staff person to whom R100 made the allegation to obtain more specific information; - the specific residents interviewed per E2's nursing note of 7/28/24 at 5:04 PM; and - the facility's "Verfication of Investigation" form that documented the following: 1. Resident observation summary of what happened; 2. Contributing factors and interventions; 3. Modified interventions to the plan of care to prevent re-occurrence (Derived from Root Cause Analysis); 4. Summary of factual investigative findings; 5. Signature and date of the Director of Nursing completing the Verfication of Investigation; and 5. Signature and date of the Executive Director. This form was not completed. 3/13/24 at 11:36 AM - During an interview, finding was reviewed with E1 (NHA), E2 (DON) and E3 (Corporate Clinical Operations). 3/13/24 at 3:45 PM - Finding was reviewed with E1, E2, E3, E4 (Regional Clinical Specialist) and representatives from the Ombudsman Office. No additional information was provided to the Surveyor.	F 610		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, it was	F 641	1.*R55's MDS was corrected.	5/9/24

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F 641	Continued From page 15 determined for three (R55, R103, R247) out of twenty three residents in the investigative sample, the facility failed to accurately completed the resident assessments . Findings include: 1. Review of R55's clinical record revealed: 2/8/23 - A physicians order was written for R55 to receive two liters of oxygen to be worn continuously. 1/30/24- A quarterly MDS assessment documented in the special treatments section that oxygen not in use by R55. January 2024 - Review of R55's MAR revealed R55 received oxygen daily. During an interview on 3/6/24 at 10:31 AM E33 (RNAC) confirmed the MDS assessment error. 2. Review of R247's clinical records revealed the following: 12/20/23 - R247 was admitted to the facility. 12/20/23- R247 had a physician's orders for the following medications for Parkinson's Disease: - amantadine 100 mg 1 tablet daily; - carbidopa/levodopa 24/100 mg 3 tablets 3x a day; - entacapone 200 mg 1 tablet 3x a day. 12/21/23 - R247 was care planned for Parkinson's disease. Interventions included but not limited to give medications as ordered by the physician and to monitor for side effects and effectiveness.	F 641	*R247's MDS was corrected. *R103 no longer resides in the facility. 2.*All residents with oxygen have the potential to be affected. *The facility conducted an audit of current residents' MDS with oxygen ordered for coding accuracy. Corrections made accordingly. *All residents diagnosed with Parkinson's Disease have the potential to be affected. *The facility conducted an audit of residents with neurological conditions for MDS coding accuracy. Corrections made accordingly. *All residents with documented wounds have the potential to be affected. *The facility conducted an audit of residents with wounds for MDS coding accuracy. *Corrections made accordingly. 3.*RCA found E33 new in her role as an MDS Coordinator, resulted in coding errors. *The RCA determined that E33 was new in her role as an MDS Coordinator and made errors in coding. *Director of Clinical Service/Designee will re-educate MDS coordinators on how to code the Specialty Treatment, the Neurological Diagnosis, and Skin Conditions section of the MDS. *Weekly, the DON/designee will audit 25% of new MDS's and discharge MDS's for accuracy of the Specialty Treatments, Neurological Diagnosis, and Skin Condition sections. 4.*Audit results will be reported in monthly	

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F 641	Continued From page 16 12/26/23 - R247's Admission MDS (Minimum Data Set) assessment lacked evidence that Parkinson's Disease was included and accurately coded under the Neurological Diagnoses section of the MDS. 3/11/23 10:24 AM - In an interview, E37 (RNAC) confirmed that R247's admission MDS was not accurately coded and that Parkinson Disease should be added in R247's list of neurological diagnosis. 3. Review of R103's clinical record revealed: 7/1/22 - R103 was admitted to the facility with diagnoses including diabetes, muscle weakness and dementia. 2/21/23 - R103's care plan documented, " ...Actual impairment to skin integrity related to unstageable wound to sacrum." 9/1/24 - R103's medical records (face sheet) updated to included, "Pressure -induced deep tissue of sacral region". 9/1/23 R103's medical records documented, "Sacral wound 2 x 4 cm observed". 9/2/23 - R103's medical records documented, "Deep tissue injury". 10/17/23 - E32 (Wound MD) documented, "Pressure injury (unavoidable stage 3)." 10/24/23 - E32 documented," ...Pressure injury (unavoidable stage 3)." 10/31/23 - E32 documented," ...Pressure injury	F 641	QA&A meetings until achieving 100% compliance for three consecutive months and PRN as indicated.	

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F 641	Continued From page 17 (unavoidable stage 3)." 11/7/23 - E32 doumented, "...Pressure injury (unavoidable)." 11/8/23 - R103 was sent the the hospital, and was diagnosed with sepsis. 11/8/23 - R103's (Discharge/Anticipated Return) MDS documented, "No pressure ulcer". 3/8/24 12:45 PM - During an interview E33 (MDS Coordinator) stated, "The MDS assessments dated 11/8/23 did not include the pressure ulcers". The facility failed to accurately document R103's pressure ulcer in the discharge MDS assessment. 3/13/24 3:45 PM -Findings were reviewed with E1 (NHA), E2 (DON), E3 (Corporate Clinical Operations) , E4 (Regional Clinical Specialist), and representatives from the Ombudsman Office.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -	F 656		5/9/24

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F 656	Continued From page 18 (i) 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 §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on record review, it was determined that for one (R95) out of twenty-three residents reviewed for care plans, the facility failed to develop and implement a person-centered care	F 656	1. *R95 is no longer receiving IV antibiotics. 2. *All residents receiving IV antibiotics	

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F 656	Continued From page 19 plan that accurately reflected R95's medical needs. Findings include: Reviw of R95's record revealed: 12/18/23 - E46 (hospital Infectious Disease MD) documented in R95's Progress Note Infectious Disease, "Sepsis - repeat [blood] culture - negative... Endocarditis-Vegetation is small...continue ceftriaxone for total of 6 weeks. Stop date will be January 19, 2024." 12/21/23 - R95 was admitted to the facility with diagnoses including, but not limited to, heart disease and anxiety. 12/22/23 - R95's care plan included a focus stating, "the resident is on IV medications r/t (related to) sepsis" with interventions that address the IV access. The interventions do not document the location (LUE) or type of access (PICC). The care plan also included a focus stating, "the resident is on antibiotic therapy related to sepsis" with interventions that fail to name the specific antibiotic and address the duration of the antibiotic. Both care plan focuses incorrectly identify the diagnosis warranting the therapy as sepsis. R95 no longer had active sepsis as proven by the negative blood culture documented by the Infectious Disease physician on 12/18/23. R95 was being treated with 6 weeks of IV antibiotics for endocarditis. 3/13/24 3:45 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (Corporate Clinical Operations), E4 (Regional Clinical Specialist) and representatives from the Ombudsman office.	F 656	have the potential to be affected. *The facility conducted an audit of 100% of residents receiving IV antibiotics: *Review of care plans for documentation of location, access, type of antibiotic, and duration. *Corrections made accordingly. 3. *RCA found licensed nursing staff did not follow procedure for care planning IV antibiotics. *Staff Developer/designee to re-educate licensed nursing staff on IV antibiotic care planning procedure, including documentation of location, access, type, and duration. *DON/designee to conduct weekly audits of 100% of residents receiving IV antibiotics to monitor documentation of location, access, type, and duration. 4. 4. *Audit results will be reported in monthly QA&A meetings until achieving 100% compliance for three consecutive months and PRN as indicated.	
F 657 SS=D	Care Plan Timing and Revision	F 657		5/9/24

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F 657	Continued From page 20 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. (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 record review and interview it was determined that for two (R31, and R296) out of twenty-three residents investigated facility failed to revise the care plan to reflect the current care needs. Findings include: 1. Review of R31's clinical record revealed:	F 657	1. *R31's care plan updated to include restorative walking. *R296's care updated to account for hospitalizations. 2. *All residents receiving restorative walking have the potential to be affected. *The facility conducted an audit of 100%	

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F 657	Continued From page 21 2/1/24- A quarterly MDS assessment documented in the special services section that R31 received restorative services of walking training and range of motion (ROM). 2/1/24 - R31's restorative services care plan was reviewed/revised and included interventions of active ROM for 15 minutes, contractures measurements, document visual changes, report changes or discomfort, provide assistance with devices. Interventions listed did not include walking R31. Review of currently in use but undated CNA Task list for care of R31 indicated the resident is to participate in the restorative walking program and ambulate with walker 30 ft daily or as tolerated. During an interview on 3/6/24 at 10:10 AM E58 (RN) unit manager confirmed that interventions related to walking were not included in the restorative services care plan for R31. 2. Review of R296's clinical record revealed: 6/30/23 - R296 was admitted to the facility with multiple diagnoses, including kidney cancer and chronic kidney disease. R296 was admitted to the facility directly from a hospital stay during which he had a nephrostomy tube (tube placed to drain urine) placed in his left kidney. R296's left kidney was unable to drain urine related to his kidney cancer. R296 was admitted to the hospital from the facility on the following dates because his nephrostomy tube became dislodged: 8/18/23, 10/14/23, 11/18/23, 12/19/23 and	F 657	of residents receiving restorative walking for accuracy and updates made accordingly. *All residents hospitalized have the potential to be affected. The facility conducted a audit of 100% of residents hospitalized in the past 30 days for accuracy and updates made accordingly. 3.*The RCA was determined that the staff failed to adhere to the facility's policy regarding care plan timing and revision. *The Staff Developer/designee will re-educate license nurses on the facility's policy regarding care plan timing and revision. *The DON/designee will conduct weekly audits of 25% of residents on restorative walking programs for accuracy. *The DON/designee will conduct weekly audits of 50% of residents that are re-admitted to the facility after hospitalization to monitor that care plans have been updated. 4.*Audit results will be reported in monthly QA&A meetings until achieving 100% compliance for three consecutive months and PRN as indicated.	

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F 657	Continued From page 22 1/24/24. 3/1/24 - A review of R296's 1/2/24 quarterly Resident Assessment Instrument and the comprehensive care plan, updated 2/28/24, revealed the lack of care plan revisions to reflect monitoring for nephrostomy tube dislodgement and the hospitalizations that R296's had for nephrostomy tube dislodgement on the above dates. 3/7/24 10:20 AM- E47 (LPN) confirmed that R296's care plan had not been revised to reflect his many hospitalizations since he was admitted to the facility. 3/13/24 3:45PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (Corporate Clinical Operations), E4 (Regional Clinical Specialist) and representatives from the Ombudsman Office.	F 657		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for five (R37, R63, R96, R446, R447) out of twenty-three residents reviewed for care plans, the facility failed to meet professional standards of the Delaware Board of Nursing Scope of Practice by having LPNs complete the admission assessment and admission progress note. Findings include:	F 658	R37, R63, R96, R446, R447 are no longer residents of the facility. All residents admitted to the facility have the potential to be affected. RCA found that the facility lacked a system requiring RNs to complete	5/9/24

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F 658	Continued From page 23 Delaware State Board of Nursing - RN, LPN and NA/UAP Duties 2023 ... Admission Assessments * - RN ... *= Once a care plan is established, the LPN may do assessments ...". The Braden Scale is a validated tool designed to assess a patient's risk of developing pressure ulcers. National Library of Medicine, Nov. 21, 2022. Cross refer F660, F695, F677 1. Review of R37's clinical record revealed: 2/17/24 - R37 was admitted to the facility. 2/17/24 - E68 (LPN) completed the dehydration risk and the Braden scale for prediction of pressure ulcer risk evaluations in R37's electronic medical record (EMR). 2/17/24 4:00 AM - E68 (LPN) wrote R37's clinical admission note in R37's EMR. 2/24/24 - E31 (LPN) completed the elopement form in R37's EMR. An LPN, not an RN as required by the Delaware State regulation for Board of Nursing Scope of Practice, completed the admission process for R37. 2. Review of R63's clinical record revealed: 1/29/24- R63 was admitted to the facility. 1/29/24 - E69 (LPN) completed R63's clinical admission form, elopement, fall risk, dehydration	F 658	admission assessments. •Facility developed a system for RNs to complete admission assessments for residents admitted and readmitted to the facility. • DON/designee to educate licensed nurses on the new system. • Weekly audits by DON/designee 25% of admissions to monitor implementation of the new system. • Audit results will be reported in monthly QA&A meetings until achieving 100% compliance for three consecutive months.	

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F 658	Continued From page 24 risk and Braden scale for prediction of pressure ulcer risk evaluations in R63's EMR. 1/29/24 5:49 PM - E69 wrote R63's clinical admission note in R63's EMR. An LPN, not an RN as required by the Delaware State regulation for Board of Nursing Scope of Practice, completed the admission process for R63. 3. Review of R96's clinical record revealed: 11/18/23 - R96 was admitted to the facility. 11/18/23 - E31 (LPN) completed R96's clinical admission form, elopement, fall risk, dehydration risk and Braden scale for prediction of pressure ulcer risk evaluations in R96's EMR. 11/18/23 5:20 PM - E31 wrote R96's clinical admission note in R96's EMR. An LPN, not an RN as required by the Delaware State regulation for Board of Nursing Scope of Practice, completed the admission process for R96. 4. Review of R446's clinical record revealed: 2/21/24 - R446 was admitted to the facility. 2/21/24 - E69 (LPN) completed R446's clinical admission form, elopement, fall risk, dehydration risk and Braden scale for prediction of pressure ulcer risk evaluations in R446's EMR. 2/21/24 9:19 PM - E69 wrote R446's clinical admission note in R446's EMR.	F 658		

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F 658	Continued From page 25 An LPN, not an RN as required by the Delaware State regulation for Board of Nursing Scope of Practice, completed the admission process for R446. 5. Review of R447's clinical record revealed: 2/19/24 - R447 was admitted to the facility. 2/19/24 - E70 (LPN) completed R447's clinical admission form, elopement, fall risk, dehydration risk and Braden scale for prediction of pressure ulcer risk evaluations in R447's EMR. 2/19/24 10:50 PM - E70 wrote R446's clinical admission note in R447's EMR. An LPN, not an RN as required by the Delaware State regulation for Board of Nursing Scope of Practice, completed the admission process for R447. 3/7/24 4:51 PM - During an interview, E69 (LPN) confirmed that he completed the admission process for R63 on 1/29/24 and R446's admission paperwork on 2/21/24. 3/6/24 9:23 AM - During an Interview, E31 (LPN) stated that whichever nurse is assigned the room for the new admit patient, that nurse completes the admission process paperwork. 3/6/24 10:01 AM - During an interview, E58 (RN Unit manager) stated, "If an admission comes in on day shift, the Unit manager processes the admission by calling the NP/MD and verifying the hospital orders for medications and treatments and then puts the orders in the computer [EMR].	F 658		

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F 658	Continued From page 26 Then the unit manager starts the care plan. If a patient is admitted on an off shift, the nursing supervisor is suppose to complete the admission process paperwork. The admission process includes the clinical admission form, the elopement risk evaluation, the fall risk evaluation, the dehydration evaluation and the Braden scale for prediction of pressure ulcers evaluation. It also includes writing a general admission note in the EMR." 3/11/24 10:57 AM- During an interview, E30 (ADON) stated that the word "assessment" is not in any of the admission paperwork. When asked where the State required RN admission assessment was for these residents, E30 stated that she did not know and to check with the DON. 3/13/24 3:45 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (Corporate Clinical Operations), E4 (Regional Clinical Specialist) and representatives from the Ombudsman office.	F 658		
F 660 SS=D	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each	F 660		5/9/24

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resident.
(ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes.
(iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan.
(iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs.
(v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan.
(vi) Address the resident's goals of care and treatment preferences.
(vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community.
(A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose.
(B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities.
(C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why.
(viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care

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F 660	Continued From page 28 provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R96) out of three residents reviewed for discharge, the facility failed to assess R96's functional abilities and consider R96's caregiver's availability and capability to perform required care, to re-evaluate and update R96's changing needs, to show evidence of the Interdisciplinary team (IDT) involvement in the process and to document R96's community referrals and contact information. Findings include: Cross refer F582 Review of R96's clinical record revealed: 11/18/23 - R96 was admitted to the facility with	F 660	.*R96 no longer resides at the facility. 2.*All residents that are being discharged have the potential to be affected. 3.*The RCA determined that the facility lacked a secondary check on discharge paperwork for completeness, including the inclusion of the PCP's name if known and the name of the Home Health Agency with contact information. *As a result, a secondary review of discharge paperwork will now be conducted. *The Staff Developer/designee will re-educate SSWs and licensed nurses on the discharge form and the need for a second check. *Additionally, the RCA revealed that there	

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F 660	Continued From page 29 diagnoses, including but not limited to, ataxia (poor muscle control that causes clumsy movements) and weakness. 11/25/23 - R96's admission Minimum Data Set (MDS) assessment documented that R96 had a Brief Interview for Mental Status (BIMS) score of 11, which is reflective of moderate cognitive impairment. 11/25/23 - R96's admission MDS documented in Section H Bowel and Bladder that R96 was "frequently incontinent" for both urinary and bowel continence. R96's admission MDS documented in Section GG Functional Abilities and Goals that R96's Admission Performance for Toileting required "substantial/max (maximum) assistance with R96's Discharge Goal for Toileting was "set up or clean up assistance". In the week prior to R96's discharge (12/13/23 to 12/20/23), the CNAs documented 18 episodes of Toilet usage Self Performance in the CNA Task section of PCC. Of those 18 episodes, two were documented as limited assistance, which was defined as "resident highly involved in activity; staff provided guided maneuvering of limbs or other non-weight bearing assistance,"ten instances were documented as extensive assistance, which was defined as " resident involved in activity, staff provide weight-bearing support," and six instances were documented as total dependence, which was defined as "full staff performance". 11/25/23 - R96's admission MDS documented in Section GG Functional Abilities and Goals that R96's Admission Performance for Mobility documented R96's Toilet transfer, Sit to stand	F 660	was no established process for handling discharges when family members refuse care training for residents with a BIMS score less than 12. *Now, the facility will hold an IDT meeting to discuss how to proceed with recommendations on discharge planning in such cases. *The Staff Developer/designee will educate the IDT on the new process. *The Social Worker/designee will conduct weekly audits of 100% of discharge papers to monitor for the name of the Home Health, PCP if known, and a second check. 4.*Audit results will be reported in monthly QA&A meetings until achieving 100% compliance for three consecutive months and PRN as indicated.	

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transfer and Chair to bed transfer as "Supervision or touching assistance" with R96's Discharge Goal for Mobility being documented as "Independent."

12/18/23 11:27 AM - E30 (ADON) documented in a fall note regarding fall on 12/14/23, " ...Resident is a/o (alert and oriented) x 2 (person, place) with periods of confusion. She requires 2 person assist with transfers/ambulation. She has a history of falls ...".

12/19/23 5:56 PM - E57 (PT) documented in the "Physical Therapy Discharge Summary Long Term Goals- ... 2. Patient will safely perform functional transfers with Modified Independence and 0% verbal cues and 0% Visual cues ... PLOF (previous level of function [prior to onset]) Transfers I (Independent) Discharge (12/19/2023) Mod A (moderate Assist)." Physical Therapy Discharge summary documented, "Patient response: Progress and Response to Tx (treatment): Patient fluctuates between functional mobility levels of assist between sessions, pt (patient) fluctuates from min (minimum) to max (maximum) assist based on day. Pt will dc (discharge) home with family assistance for mobility."

12/20/23 11 AM - R96 was discharged from the facility to F1's (R96's granddaughter) care. R96 had lived with F1 for the past 13 years.

The facility lacked evidence of educating F1 about R96's mobility levels prior to discharge to ensure R96's care and continued safety could be met.

3/8/24 1:52 PM - During a telephone interview, F1

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(R96's granddaughter) stated, "We thought Grandmom could walk to the bathroom so we did not order any new equipment. We had to go out and get a bedpan and bedside commode ...It took three of us to get her into the car, me, my mom and one of the nurses helped us by pulling her into the car from the other side. She fell 5 times in the 2 days that she was home after being discharged from the facility. Prior to this hospitalization, Grandmom could walk independently and go outside with my kids. I work from home but I was not able to constantly supervise and assist her. We thought she could walk ...They never contacted me to discuss plans about discharge."

The facility was not able to provide evidence of social work or any employees contacting F1, whom R96 lived with, to discuss the discharge plans and process and to educate F1 regarding R96's care needs.

3/8/24 3:41 PM - During a second telephone interview, F1 (R96's granddaughter) stated, "We weren't given any of her meds. They gave me a script for 2 new meds, Nortriptyline and Macrobid for a UTI (urinary tract infection). When I went to get the Macrobid filled at the pharmacy, they would not fill it- something about it was already filled per the insurance. The paperwork was terrible. It did not have the name of her PCP (primary care physician) and it didn't say which home care agency was contacted to come to the house."

3/11/24 9:35 AM - During an interview, E55 (Social Worker) stated that the social worker involved in R96's discharge no longer works at the facility. "The process for discharge is once

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Social work services is aware from morning meeting/IDT (interdisciplinary team) meeting that a resident is going home, they initiate conversations with the resident/family about needs. I personally fax referrals to the home health agency and then document in the discharge plan the name and contact information for the home health agency. I don't put copies of the fax into PCC (Point click care). I do discuss with family if the resident is confused or has a cognitive impairment."

The facility failed to document on the discharge plan the name and contact information of the home care agency that would be providing the care.

3/11/24 11:02 AM - During an interview, E30 (ADON) stated, "The Unit Manager and Social Worker start the discharge plan of care and then the discharging nurse should update it before the resident leaves to go home. The resident or family then signs the paperwork and we keep the signed copy. The nurse should put the PCP name and contact information and the home health agency referral name and contact information on the form."

3/19/24 12: 00 PM- During an interview, E38 (Director of Rehab services) stated, "[E96], about 8 days prior to her discharge, stopped doing the full therapy session. She would say that she was tired or didn't need to do that because I am going home. She would not fully participate. Up to that time, she was doing great. R96's daughter was here every day and I did speak to her about her mom not participating in the entire therapy session. The daughter said that she would talk to her mom but that her mom was stubborn." E38

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also stated that she had called and offered F1 (R96's granddaughter) the opportunity to come in and get care training. The granddaughter [F1] did not feel she needed to be trained as she has been caring for R96 for the past 13 years. E38 also stated that the therapy department did recommend home therapy after discharge but the doctor writes the therapy prescriptions and social work contacts the home therapy companies. E38 was not aware that the home therapy company name and contact information was not documented on R96's discharge paperwork.

3/19/24 12:45 PM - During an interview, E1 (NHA) stated that one of their social workers, who was in charge of R96's discharge, walked out the door on 12/20/23 at 9:59 AM. "she just got up and left the building and never came back."

3/19/24 1:15 PM - During an interview, E58 (RN unit manager) reported that the F1 came back in the facility after getting R96 in her car on 12/20/23 and she was upset that R96 struggled to get in the car. "We offered to let R96 stay for more therapy as R96 still had remaining therapy days left." E58 reported that F1 (R96's granddaughter) stated that R96 did not want to come back for more therapy and "maybe we will take her back to the hospital".

3/19/24 1:33 PM - During a telephone interview, E67 (hospital home care agency RN) stated that [home care agency] did receive referrals for R96 for nursing, PT (physical therapy) and OT (occupational therapy). Their agency never started services because R96 was discharged from the facility on 12/20/23 but then was readmitted to [hospital] on 12/21/23 and after that went to another rehab facility.

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F 660	Continued From page 34 3/19/24 2:45 PM - Findings were reviewed with E1 (NHA), E2 (DON), and E3 (Corporate Clinical Operations).	F 660		
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was	F 661	1.*R247 no longer resides in the facility.	5/9/24

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F 661	Continued From page 35 determined that for one (R247) out of 3 residents reviewed for discharge, the facility's discharge summary failed to accurately capture and document R247's post-discharge plan of care. Findings include: Review of R247's clinical records revealed the following: 12/20/23 - R247 was admitted to the facility from the hospital. 1/18/24 4:36 PM - A nurse progress notes documented that R247 had an unwitnessed fall that resulted to a skin tear to his left arm and lacerations to the left eye and left cheek. 1/18/24 - R247 had the following physician's orders: - monitor steri strips (used for cuts or wounds that are not too severe); - cleanse skin tear to left cheek with soap and water, apply bacitracin and leave open to air; - cleanse skin tear to left elbow with soap and water, apply bacitracin and cover with dry dressing daily. 1/19/24 - R247 was discharged home via ambulance. 3/11/24 10:59 AM - Review of the form titled "BVC - Discharge Instructions and Post Discharge Plan of Care - Version 3" revealed a lack of discharge instructions for wound care. 3/11/24 1:20 PM - During an interview, E37 (RN) confirmed that R247's wound care treatment orders were not documented in the discharge paperwork.	F 661	2.*All residents that are discharged from the facility with wounds have the potential to be affected. 3.*The RCA determined that the facility lacked a secondary check on discharge paperwork for completeness, including treatment orders for wounds. As a result, a secondary review of discharge paperwork will now be conducted. *The Staff Developer/designee will re-educate SSWs and licensed nurses on the discharge form and the need for a second check. *The Licensed Nurse/designee will conduct weekly audits of 100% of discharge papers to monitor for treatment orders and second check. The Staff Developer/designee will re-educate SSWs and licensed nurses on the discharge form and the need for a second check. 4.*Audit results will be reported in monthly QA&A meetings until achieving 100% compliance for three consecutive months and PRN as indicated.	

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F 661	Continued From page 36 3/13/24 3:45 PM -Findings were reviewed with E1 (NHA), E2 (DON), E3 (Corporate Clinical Operations) and E4 (Regional Clinical Specialist) and representatives from the Ombudsman Office.	F 661		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for one (R31) out of one resident reviewed for rehab and restorative the facility failed to ensure R31 received restorative services consistently when R31 was not walked daily. Findings include: Review of R31's clinical record revealed: 1/17/24 - The CNA Task list for the care of R31	F 688	1.*R31's walking restorative program is now being documented. 2.*All residents on a walking restorative program may be affected. 3.*The RCA determined that the facility lacked the ability for the restorative aide to document if the resident was assigned to another C.N.A. The facility now has the	5/9/24

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F 688	Continued From page 37 was revised to include the resident is to participate in the restorative walking program and ambulate with walker 30 foot daily or as tolerated. 2/1/24- A Quarterly MDS assessment documented in the special services section that R31 received restorative services of walking training and range of motion (ROM). During an interview on 2/29/24 at 12:04 PM R(31) stated, " I was told I had graduated to walking therapy but getting that has been hit or miss". February 2024 - Point of care (POC) CNA responses for assisting R31 to walk lacked evidence that the resident was assisted with walking on the following dates: 2/1, 2/2, 2/3, 2/4, 2/6, 2/10, 2/17, 2/18, 2/19, 2/20, 2/22, 2/24 and 2/25. During an interview on 3/5/24 at 1:00 PM E58 (RN) unit manager stated, "I just talked with some of the aides, they said when an extra aide is assigned restorative they document n/a because then it's not their responsibility". When asked how nursing verifies that the walking was completed, E58 stated, "They should be documenting that it's completed". 3/13/24 3:45 PM -Findings were reviewed with E1 (NHA), E2 (DON), E3 (Corporate Clinical Operations) , E4 (Regional Clinical Specialist) and representatives from the Ombudsman Office.	F 688	capability for the restorative aide to document. *The Staff Developer/designee will educate the C.N.A.'s and restorative aide on the new system for documenting. *The DON/designee will audit 50% of residents on a restorative walking program for accuracy of documentation. 4.*Audit results will be reported in monthly QA&A meetings until achieving 100% compliance for three consecutive months and PRN as indicated.	
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that -	F 689		5/9/24

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F 689	Continued From page 38 §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that for two (R248 and R6) out of six residents reviewed for accidents, the facility failed to ensure residents were free from accident hazards and/or were provided adequate supervision to prevent accidents. R248 sustained harm when the facility failed to ensure staff provided supervision and assistance with care resulting in a fall with facial bone fractures. For R6 the facility failed to ensure the resident environment was free of an accident hazard. Findings include: 1. Review of R248's clinical record revealed the following: 5/15/23 - R248 was admitted to the facility with diagnoses including but not limited to history of fall(s) and a broken pelvis (the lower part of the trunk between the abdomen and thighs). 5/15/23 - R248 was care planned for self care deficit related to decrease in functional mobility, strength, balance and endurance and interventions included: - one person assist with bed mobility, one person assist with transfers, toileting, bathing and dressing, Set up assist with eating; - Encourage independence in ADL care, but offer assistance as needed.	F 689	1.*R248 no longer resides in the facility. *R6□s fall mats are no longer on the floor when she is out of bed. 2.*All residents have the potential to be affected. 3.*The Staff Developer/designee will re-educate C.N.A.'s and licensed nurses on "CMS's RAI Manual Section G, Functional Status of Activities of Daily Living (ADL) Assistance." *The RCA revealed that that E36 could have benefited from additional training regarding bedside care including type of assistance required. Licensed Nursings and C.N.A.'s will be re-educated on the appropriate protocols and methods of bedside care as determined by type of assistance required. *The RCA revealed staff did not follow the facility protocol of picking up fall mats when the resident is out of bed. *The Staff Developer/designee will re-educate C.N.A.'s, housekeeping, and licensed nurses on the need to pick up fall mats when residents are out of bed. *The DON/designee will conduct weekly rounds to audit for fall mats. *The Regional Support/designee will review 10% of section G of the MDS for	

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F 689	Continued From page 39 5/16/23 - A PT (Physical Therapy) Evaluation documented that R248's functional assessment for bed mobility was SBA (Stand - by Assist). In addition, the PT assessment summary noted, "..."pt (patient) presents with reduced activity tolerance and strength needed to return to PLOF (previous level of function), Pt c/o (complained of) 7/10 pain (pain scale for severe pain in a scale of 0-10) in B (bilateral) hips and low back which limits ability to return to PLOF....Risk Factors: Due to the documented physical impairments and associated functional deficits, the patient is at risk for falls and further decline in function." 5/20/23 10:43 AM - A nurse progress note documented, "...resident lying on her left side on the floor... c/o (complained of) 'pain all over body' & yelled when left shoulder and left hip palpated...unable to indicate how she got to floor... send to (hospital) as per order via... NP (Nurse Practitioner). 911 notified...Resident left the facility at 10:30 ..." 5/20/23 12:20 PM - Review of the [hospital ER] physician record documented, "...Patient states that she was in her usual state of health...in her bed when she rolled out into the floor while sleeping...She struck her head on the floor sustaining bruising of her face...states that she is having pain over her face...left shoulder right hip pain..." 5/20/23 9:55 AM - Facility incident report revealed that, "Resident was observed lying on the floor in her room. When asked what happened, she did not respond to the question during assessment, she complained of pain to her L (left) shoulder and L hip. Order was received to send her out to the ER for further evaluation...Resident was	F 689	coding. *The DON/designee will make 4 observations per week of residents receiving care at bedside for implementation of ADL assistance. 4.*Audit results will be reported in monthly QA&A meetings until achieving 100% compliance for three consecutive months and PRN as indicated.	

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F 689	Continued From page 40 transferred to the ER at 10:30 AM..." The Facility's 5 day follow up summary documented, "...resident complained of generalized body pain including left shoulder and left hip pain which was exacerbated by movement...resident was sent to ER (Emergency Room) and returned 5/20/23 2300 (11:00 PM)...CT (computerize tomography scan, an imaging test that takes detailed pictures of the inside of the body) of the facial bone was positive for an acute left tripod fracture (facial bone fracture)...Interview with staff showed that the fall was witnessed. The fall occurred when the assigned aid (CNA)was providing care to the resident who is a 1 person assist with bed mobility. The aid turned the resident to her side, at which time the resident suddenly rolled off the bed before the CNA could break the fall..." 5/22/23 - R248's Admission MDS (Minimum Data Set) assessment revealed that R248 had a moderately impaired cognition, required extensive assist of one person for bed mobility and toileting during the review period. An extensive assist of one person staff means that a resident is involved in an activity but the one person staff provides the weight bearing support. Review of R248's May 15, 2023 through May 20, 2023 CNA flowsheet revealed that R248 was an extensive assist of one person staff in 6 out of 14 opportunities, two times on the 3-11 shift and four times during the 11-7 shift. 3/12/24 11:00 AM - Review of the facility's incident report and investigation revealed an undated written statement by E36 (CNA) and documented, "I was changing [R248] (sic) I raised	F 689		

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F 689	Continued From page 41 the bed to my waist. She crossed her leg over but put her leg over to (sic) far and fell onto the floor. She fell onto the floor and began to complain of her face and left knee hurting. I notified the nurse immediately, her vitals were checked and I waited for the EMT (Emergency Medical Technicians) to come and take her to the hospital." 3/12/24 11: 42 AM - A telephone interview with E36 revealed that she was not familiar with the resident [R248] and it was her first time taking care of her. E36 also stated that she was at the resident's bedside "to change her ". CNA further stated that she raised the bed with R248 on the bed, turning to be changed. R248 crossed her leg to turn to her side "but she crossed her leg way too far that she rolled on to the floor and fell. I did not touch and I did not hold to support her as she was moving on her own. She moved and crossed her legs on her own." Despite the history of a fall at home resulting in an injury and a subsequent hospitalization with a fall risk and high risk of injury designation, the facility failed to ensure R248's safety when E36 turned R248 to her side while providing personal care without touching or holding to support R248, at which time R248 rolled off the bed and had a fall which resulted in facial bone fractures. 2. Review of R6's clinical record revealed: Review of the facility's policy and procedure titled "Fall Prevention last updated 4/1/20, documented... 1. "Fall prevention is achieved through an interdisciplinary approach of managing risk factors and implementing appropriate interventions to reduce the risk of falls... 2. Potential interventions may include	F 689		

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exercise, environmental modification, medication, assistive devices, footwear etc... 3. Develop a plan of care which can include general and specific interventions to reduce fall risks."

4/6/23 - Review of R6's care plan for falls revised 1/30/24 documented ..."1. At risk for falls related to cognitive deficits, impaired mobility, gait/balance problems, impulsiveness, and poor safety awareness... 2. Fall mats at both sides while in bed... 3. Resident needs a safe environment with even floors free from spills and or clutter... 4. Every one hour checks."

9/17/23 - R6 was readmitted to the facility with diagnoses include dementia, schizoaffective disorder bipolar type, Parkinson disease, osteoarthritis, abnormality of gait and balance and muscle weakness.

12/19/23 - Review of R6's quarterly MDS Assessment documented R6 was severly impaired for daily decision making with a BIMS of 5 and that R6 required partial moderate assist to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed. Additionally, R6 required partial moderate assist to transfer to and from a bed to chair or wheelchair.

2/11/24 12:12 AM - Review of R6's fall evaluation form documented ..."1."Balance problem while standing."

2/29/24 11:30 AM - R6 was observed in her room sitting in the wheelchair. R6 had fall mats down on the floor at both sides of the bed, while R6 was not in bed. In addition, R6 was observed self-propelling her wheelchair towards the bed, stopped the wheelchair at the edge of the fall mat

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on the floor, stood up and walked on the fall mat and leaned over onto the bed to pick up R6's stuffed animal from the center of the bed.

3/1/24 11:02 AM - R6 was observed being assisted back to her room by E40 (CNA). E40 left the room and R6 remained sitting up in her wheelchair with fall mats on the floor at both sides of the bed.

3/1/24 2:26 PM - The third observation in R6's room revealed fall mats at both sides of the bed on the floor while R6 was sitting up in the wheelchair in her room.

3/5/24 10:09 AM - R6 was up and out of bed sitting in the wheelchair in her room. Fall mats at both sides of the bed on the floor.

3/5/24 11:02 AM - During an interview E40 revealed "R6 had falls that's why the fall mats are down."

3/5/24 12:43 PM - During an interview E41 (LPN) revealed, "[R6] is at risk for falls, and that the fall mats on the floor are a precautionary measure if R6 happens to fall at the bedside."

3/5/24 1:03 PM - During an interview E37 (RN) stated, "the fall mats on the floor in [R6's] room provided a cushioned area for [R6] to fall on to if [R6] had a fall." After E37 reviewed R6's care plan for falls E37 confirmed, "the fall mats should be on the floor when [R6] is in the bed." The fall mats in R6's room were picked up from the floor as R6 was observed to be sitting in the wheelchair in her room.

The facility did not provide R6 a safe environment

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F 689	Continued From page 44 in her room. R6's care plan was not followed as fall mats were only to be placed on the floor at both sides of the bed when R6 was in bed. 3/13/24 3:45 PM -Findings were reviewed with E1 (NHA), E2 (DON), E3 (Corporate Clinical Operations) and E4 (Regional Clinical Specialist) and representatives from the Ombudsman Office.	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, it was determined that for one (R63) out of one resident reviewed for respiratory, the facility failed to provide care consistent with the professional standards with regards to R63's albuterol nebulizer (neb) treatment. Findings include: "Albuterol (Inhalation Route) Proper Usage- ... The albuterol inhalation solution should be used with a jet nebulizer that is connected to an air compressor with good air flow ...To use the inhalation solution in the nebulizer: -Use one container of solution or mix the exact amount of solution using the dropper provided for each dose. -Place the inhalation solution in the medicine	F 695	1.*R63 is now receiving his nebulizer treatment as per the facility's policy. 2.*Residents receiving nebulizer treatments have the potential to be affected. 3.*The RCA found the staff was not facility not following its Nebulizer Therapy policy. *The policy was reviewed with no recommended changes. *The Staff Developer/designee will re-educate licensed nurses on the facility's Nebulizer Therapy policy. *The DON/designee will audit two nebulizer treatments per week to monitor	5/9/24

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F 695	Continued From page 45 reservoir or nebulizer cup on the machine -Connect the nebulizer to the face mask or mouthpiece. -Use the face mask or mouthpiece to breathe in the medicine. -Use the nebulizer for about 15 minutes, or until the medicine in the nebulizer cup is gone." Mayo Clinic, February 1, 2024 The facility's Nebulizer Therapy policy (dated 4/1/2020) stated, "Policy: It is the policy of this facility for nebulizer treatments, once ordered, to be administered by nursing staff as directed using proper technique and standard precautions ...Care of the resident 15. When medication delivery us complete, turn the machine off. Treatment may be considered complete with the onset of nebulizer sputtering." 9/22/23 - R63 was admitted to the facility. 12/20/23 - R63's quarterly MDS assessment documented a BIMS score of 15, which reflected normal cognition. 1/24/24 - F3's (R63's former roommate) admission MDS assessment documented a BIMS score of 15, which was reflective as having normal cognition. 2/16/24 - E63 (NP) ordered R63 "Albuterol sulfate inhalation nebulization solution (2.5 mg/3 ml) 0.083% 1 vial inhale orally four times a day for SOB (shortness of breath)." The Surveyor confirmed that R63's medication administration record (MAR) for February and March listed the times of albuterol neb treatments as 9 AM, 12 noon, 5 PM and 9 PM.	F 695	adherence to the policy. 4.*Audit results will be reported in monthly QA&A meetings until achieving 100% compliance for three consecutive months and PRN as indicated.	

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F 695	Continued From page 46 2/29/24 3:55 PM - During an interview, F4 (R63's family member) stated, "Last week, after [R63] was given his night time neb (albuterol) treatment. [R63] gets a breathing treatment from the little machine that lasts about 15 minutes. Those treatments make [R63] anxious; he does not like the facemask on his face. Well, no one came back to take the facemask off [R6] after about an hour and [R63] was getting upset. His roommate, [F3] had to call his family member at home to have her call the front desk to have someone come down to take the treatment facemask off [R63]." 3/1/24 10:20 AM - During an interview, F3 reported, "A few nights ago, after [R63] got his evening neb, which is suppose to be a 10 minute thing, they left it on for an hour. At first, I rang the call light and when no one came, I started to call out, 'Is there a nurse?' because we were both in bed. I must have yelled numerous times. Then I was planning on calling his family member (F4) but [R63] said, 'She would be in bed because it was after 10 PM.' So I called my family member and she called the front desk. Then a male nurse came in and took it (the facemask) off without saying a word." 3/1/24 10:30 AM - R63 confirmed during an interview that the incident with the neb facemask being left on his face for over 45 minutes did occur. 3/13/24 3:45 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (Corporate Clinical Operations), E4 (Regional Clinical Specialist) and representatives from the Ombudsman office.	F 695		

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F 698	Continued From page 47	F 698		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive 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, observation and interview, it was determined that for one (R446) out of one resident reviewed for dialysis, the facility failed to ensure that R446's transportation needs related to dialysis were met as evidenced by the failure to schedule/confirm transportation to dialysis on 3/6/24. Findings include: Review of R446's clinical record revealed: 2/21/24 - R446 was admitted to the facility with diagnoses, including but not limited to, end-stage renal disease (ESRD) requiring hemodialysis. 2/21/24 - R446's care plan documented, "The resident needs dialysis: hemo (hemodialysis) r/t (related to) renal failure" with Interventions stating "Dialysis (Mon/Wed/Fri) at [hemodialysis facility]. Chair time 7:20 AM. Pick up 6:00 - 6:30 AM." 3/6/24 7:15 AM - The Surveyor observed R446 sitting in a wheelchair in the facility lobby. E1 (NHA) confirmed that R446's ride to hemodialysis did not pick her and the facility was arranging another ride to get her to her dialysis treatment. This hemodialysis treatment was exactly 14 days (2 weeks) from R446's admission date.	F 698	1.*R446 no longer resides in the facility. 2.*Residents being transported to dialysis may be affected. The facility conducted a audit of 100% of residents receiving dialysis to verify transportation arrangements. Transportation arrangements were made accordingly. 3.*RCA analysis determined the facility overlooked expiration of R446's DART transportation application. The facility lacked a system to track residents receiving dialysis and expiration of their DART applications and overlooked the expiration of R446's DART transportation application. *The facility implemented a tracking system . *Staff Developer/designee to educate Unit Clerk on new tracking system. *DON/designee to conduct weekly audits of 100% of residents taking DART to dialysis. 4.*Audit results will be reported in monthly QA&A meetings until achieving 100% compliance for three consecutive months	5/9/24

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F 698	Continued From page 48 3/6/24 9:35 AM - R446 was driven to her hemodialysis treatment in the facility bus. 3/6/24 9:53 AM - During an interview, E30 (ADON) stated, "Transport to dialysis is arranged by the hospital for the first two weeks after discharge and then it is the dialysis center social worker's job to arrange the transport." 3/7/24 8:52 AM - During an interview, E48 (LPN) stated, "Normally the dialysis transport is longstanding, if they were on dialysis in the community. So [E62] (unit clerk) calls the dialysis center and lets them know where the resident is now housed and arranges for them to pick the resident up here." 3/7/24 3:35 PM - The Surveyor reviewed the facility's Long Term Facility Outpatient Dialysis Services Coordination Agreement, which stated, "Consistent with this definition, Renal Dialysis Services shall not include transportation of the ESRD residents to and from the ESRD Dialysis Unit ... Obligations of Long Term Care Facility and/or Owner - ...5. Transport and referral of ESRD Residents: A. The Long Term Care Facility shall be responsible for arranging for suitable and timely transportation of the ESRD resident to and from the ESRD Dialysis Unit, including the selection of the mode of transportation, qualified personnel to accompany the ESRD resident, transportation equipment usually associated with this type of transfer or referral in accordance with the applicable federal and state laws and regulations and all costs or transportation expenses associated with such transfer." 3/13/24 3:45 PM - Findings were reviewed with	F 698	and PRN as indicated.	

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F 698	Continued From page 49 E1 (NHA), E2 (DON), E3 (Corporate Clinical Operations), E4 (Regional Clinical Specialist) and representatives from the Ombudsman office.	F 698		
F 756 SS=C	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 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	F 756		5/9/24

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F 756	Continued From page 50 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 record review and interview, it was determined that the facility failed to provide a MRR policy with time frames for response from the provider for irregularities and a complete process for following up regarding an urgent action irregularity which included time frames for informing the provider of the urgent finding and what to do if the provider fails to response in a certain time frame. Findings include: 3/1/24 - The Surveyor reviewed the Medication Regimen Review policy dated 4/1/20 provided by the facility. "Medication Regimen Review ... Policy Explanation and Compliance Guidelines: ... 7. Timelines and responsibilities for Medication Regimen Review a. The pharmacist shall communicate any recommendations and identified irregularities via written communication within 10 working days of the review. b. If the pharmacist should identify an irregularity that requires urgent action to protect a resident, the DON or designee is informed verbally. c. Facility staff shall act upon all recommendations according to procedures for addressing medication regimen review irregularities."	F 756	.*The facility's Medication Regimen Review policy has been updated. 2.*Any resident identified with an urgent action has the potential to be affected. The facility conducted a whole house audit of pharmacy recommendations in the past 30 days to identify missed urgent timeframes. Facility will notify physician as needed. 3*.RCA determined facility's Medication Regimen Review policy lacked response timeframes for irregularities and a process for following up on urgent irregularities. *Policy updated to include response timeframes and follow-up procedures for urgent irregularities. *Staff Developer will educate licensed nurses on the updated policy. *DON/designee will conduct weekly audits of 100% of pharmacy urgent reports to monitor adherence to the policy. 4.*Audit results will be reported in monthly QA&A meetings until achieving 100% compliance for three consecutive months and PRN as indicated.	

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F 756	Continued From page 51 The facility was unable to provide evidence within their Medication Regimen Review policy of stated time frames for response from the provider for pharmacist identified and reported irregularities. The facility was also unable to provide evidence within their Medication Regimen Review policy of a complete process for pharmacist identified and reported urgent action irregularities with stated time frames for informing the provider of the urgent finding and the process the facility must take if the provider fails to response in a designated time frame. 3/13/24 3:45 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (Corporate Clinical Operations), E4 (Regional Clinical Specialist) and representatives from the Ombudsman office.	F 756		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented	F 758		5/9/24

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F 758	Continued From page 52 in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on clinical record review and interview, it was determined that for one (R2) out of five residents reviewed for unnecessary medications, the facility failed to complete an AIMS assessment for R2 a resident taking anti-psychoactive medications. For one (R198) out of one residents reviewed for behavioral-emotional distress the facility failed to effectively monitor R198 for side effects related to	F 758	1.*R2's AIMS has been completed. *R198's AIMS has been completed and the resident is receiving their Olanzapine. 2. *All residents receiving medications that require an AIMS assessment have the potential to be affected. *An audit of 100% of residents taking medications that require and AIMS	

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F 758	Continued From page 53 use of an antipsychotic medication when AIMS testing was not completed November 2022 - May 2023 during which the resident continued to receive antipsychotic medications. Additionally the facility failed to administer R198's antipsychotic medication [olanzapine] for seven doses due to lapse in pharmacy delivery. Findings include: Review of the facility's policy and procedure titled "Behavior and Psychoactive Management Program" last updated 4/1/20, documented... 1. "Monitoring for any adverse side effects of medications, which includes completion of Abnormal Involuntary Movement Scale (AIMS) as per recognized standards of practice." 1. Review of R2's clinical record revealed: 3/10/23 - R2 was readmitted to the facility with a diagnosis of dementia, psychotic disorder with delusions, anxiety, and major depressive disorder. 4/21/23 6:00 PM - A review of R2's MAR (Medication Administration Record) documented, "1."Nurse to complete AIMS quarterly one time a day every 92 days." 3/11/24 11:00 AM - Review of R2's clinical record lacked evidence that a quarterly AIMS had been completed for the use of Seroquel 25 mg two times a day and Seroquel 50 mg at bedtime for major depressive disorder and delusions for the month of October 2023. 3/11/24 11:19 AM - During an interview E37 (RN) revealed R2's AIMS evaluation is done quarterly. E37 confirmed R2's clinical record lacked a	F 758	assessment and the timeliness of their AIMS testing will be conducted. AIMS testing will be administered for any residents who have missed a scheduled test. 3.*The RCA determined that the facility lacked a tracking system for AIMS testing due dates. The facility has now established a tracking system. *Additionally, the facility did not have a backup pharmacy. Now, the facility has established one. *The DON/designee will conduct weekly audits of 50% of residents that are scheduled for AIMS testing to monitor that it was conducted. *The DON/designee will conduct a weekly audit of 100% of residents for whom medications are not available, to monitor that the facility followed protocol to obtain the medication from either the facility's pharmacy or the backup pharmacy. 4.*Audit results will be reported in monthly QA&A meetings until achieving 100% compliance for three consecutive months and PRN as indicated.	

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F 758	Continued From page 54	F 758		

quarterly AIMS evaluation for the month of October 2023.

3/11/24 12:00 PM - An interview with E2 (DON) revealed R2's AIMS evaluation should have been done in October 2023.

3/12/24 12:41 PM - During an interview E2 confirmed, "I was not able to find R2's AIMS evaluation for October 2023.

2a. Review of R198's clinical record revealed:

2/15/23- A physicians order was revised for R198 to receive Olanzapine [antipsychotic] 7.5 mg at bedtime for schizoaffective disorder. The original order was 3/16/22.

3/7/23 7:41 PM - A progress note written by E12 (NP) documented, "Patient is seen today for follow up schizoaffective disorder and medication review. Mood remains stable...Patient with mild tremors of the hands possibly extrapyramidal effects, will discuss with psych team about starting on cogentin as requested by patient".

3/10/23- A physicians order was written for R198 to receive Bentropine/cogentin 0.5mg ordered for dystonia[tremors], a side effect of antipsycotic medication use.

3/16/23 8:14 PM - A physicians note written by E65(MD) documented, "Late Entry: Patient is seen for follow up after started on cogentin for tremors secondary to antipsycotic medications. She is having improvement in her tremors."

4/21-23 - A physicians order was written for R198 to receive AIMS testing now and every 92's day,

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F 758	Continued From page 55 quarterly. 6/15/23 - AIMS testing completed for R198. Prior AIMS test was completed on 10/27/22. During an interview on 3/12/24 at 3:16 PM E2 (DON) confirmed AIM's assessments for monitoring of side effects of antipsycotic use was not complete from November 2022 through 2b. The facility's pharmacy policy on unavailable medications last updated 4/20/23 indicated, if the ordered medication is unavailable in the emergency stock supply a licensed nurse calls the pharmacy's answering service and request to speak with the registered pharmacist on call to determine a plan of action with may include: emergency delivery, use of emergency back up pharmacy. March 2023 -Review of R198's MAR revealed the Olanzapine was given to the resident 3/20/23 through 3/27/23. 3/20/23 11:22 PM - An orders administration note documented in R198's clinical record documented that the Olanzapine was not given because the facility was "awaiting delivery." 3/24/23 10:24 PM - An orders administration note documented R198's Olanzapine was, "unavailable. Pending pharmacy delivery". 3/26/23 10:46 PM - An orders administration note documented R198's Olanzapine was, "Awaiting delivery". 3/27/23 10:42 PM - An orders administration note documented R198's Olanzapine was not	F 758		

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F 758	Continued From page 56 administered because the facility was "Waiting for a medication order from the pharmacy, pharmacy has been notified". During an interview on 3/13/24 at 10:49 AM E2 (DON) confirmed that R198's Olanzapine was not avaialble for 7 days and the facility only utilizes one pharmacy at this time for fulfilling orders. E2 stated, "We are in the process of setting up a system with a back up pharmacy but have not just yet". During an interview on 3/13/24 at 1:08 PM E64 (LPN) who was assigned to R198 on 3/20 and 3/24, it was confirmed that R198's Olanzapine was not available and not administered. 3/13/24 3:45 PM -Findings were reviewed with E1 (NHA), E2 (DON), E3 (Corporate Clinical Operations) and E4 (Regional Clinical Specialist) and representatives from the Ombudsman Office.	F 758		
F 803 SS=D	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as	F 803		5/9/24

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F 803	Continued From page 57 input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that for two (R27 and R28) randomly observed residents, the facility failed to ensure that the residents received the selected food and drinks from the menu. Findings include: 2/29/24 12:15 PM - During a random dining observation of R28's lunch tray, the meal ticket did not match when R28 did not receive cranberry juice or sauteed spinach. E45 (CNA) confirmed the finding. 3/5/24 8:10 AM - During a random dining observation of R27's breakfast tray, the meal ticket did match when R27 was not served oatmeal. E40 (LPN) confirmed the finding. 3/8/24 12:58 PM - During a random dining observation of R28's lunch tray, the meal ticket did not match when R28 did not receive cranberry juice. E48 (LPN) confirmed the finding. 3/13/24 3:45 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (Corporate Clinical Operations) , E4 (Regional Clinical Specialist)	F 803	1.*R27 and R28 are now receiving all items listed on their meal ticket. 2.*All residents have the potential to be affected. 3.*RCA found kitchen not implementing checker position on tray line to monitor accuracy before trays leave. The kitchen has reimplemented the checker position. *Staff Developer/designee to re-educate staff on conducting tray accuracy tests with the checker position. *Food Service Director/designee to audit 10 trays per week for accuracy 4.*Audit results will be reported in monthly QA&A meetings until achieving 100% compliance for three consecutive months and PRN as indicated.	

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F 803	Continued From page 58 and representatives from the Ombudsman Office.	F 803		
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 serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and interview during the initial kitchen tour, it was determined that the facility failed to ensure that proper sanitation practices were in place and that food was stored in accordance with professional standards. Additionally, it was determined that the facility failed to ensure dishes were chemically sanitized when dish washing machine temperatures failed to rise to the degree required for heat sanitization. Findings include: 1. 2/29/24 from 9:00 AM to 9:20 AM, observation of the kitchen with E42 (Dietary Services Director)	F 812	1.*Food items are now labeled and dated. *Paper towels have been restocked. *Staff are wearing beard guards. *Dishwashers are running at proper temperatures. 2.*All residents have the potential to be affected. 3.*RCA determined staff not following facility's protocol for operating the kitchen. *Staff Developer/designee to re-educate kitchen staff on facility's protocol for	5/9/24

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F 812	Continued From page 59 revealed the following: " E43 (Dietary Aide) did not have a hair net or beard covering in place. " The hand washing sink had no paper towels available. " The walk-in freezer had two containers of what appeared to be soup and one container of what appeared to be gravy, all without content description labels, dates of preparation and expiration. The above findings were immediately confirmed with E42. 2. The Wareforce dish washing machine [brand used by the facility] manual indicated 140°F temperature and chlorine/bleach required for sanitization of dishes. https://www.jacksonwws.com/wp-content/uploads/2018/11/WAREFORCE-I-Manual-Rev-K.pdf. The [undated] facility policy on "Warewashing" indicated, "all dish machine washing temperatures will be maintained in accordance with manufacturer recommendations for high temperature or low temperature machines. During the follow up kitchen tour on 3/1/24 at 10:29 AM - 10:47 AM the following was observed: 10:39 AM - Single rack dish washing machine wash cycle 130 degree's F, with no chemical sanitization attached. 10:42 AM - Single rack dish washing machine wash cycle 130 degree's F, with no chemical sanitization attached. 10:45 AM - E42 (DDS) confirmed the dishwashing temperatures and stated, "We use bleach attached to sanitize, it has had issues but	F 812	operating the kitchen, including labeling and dating, stocking paper towels, wearing beard guards, and running sanitizing chemicals if dishwashers are not at proper temperatures. *FSD/designee will conduct weekly kitchen inspections to monitor facility's protocol. 4.*Audit results will be reported in monthly QA&A meetings until achieving 100% compliance for three consecutive months and PRN as indicated.	

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F 812	Continued From page 60 has been fine lately. We have had maintenance come out." The Surveyor requested E42 (DDS) to point out the attached sanitizing agent/bleach. E42 then confirmed it was not attached. 10:47 AM - E42 (DDS) retrieved a replacement of sanitizer/bleach and connected it to the dishwashing machine. Nearby dishes were re-ran the dish washing machine with the added sanitization/bleach. 3/13/24 3:45 PM -Findings were reviewed with E1 (NHA), E2 (DON), E3 (Corporate Clinical Operations) , E4 (Regional Clinical Specialist) and representatives from the Ombudsman Office.	F 812		
F 842 SS=B	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential	F 842		5/9/24

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F 842	Continued From page 61 all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;	F 842		

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F 842	Continued From page 62 (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for six (R42, R47, R63, R76, R98 R107, R108) out of twenty-three residents records reviewed, the facility failed to maintain and safeguard medical records information on each resident against loss and ensure the records are complete, accurately documented and readily accessible. Findings include: 1. R98's clinical record revealed: 3/5/22 - R98 was admitted to the facility and discharged 10/13/23. Review of the R98's paper chart and the electronic clinical record lacked evidence of R98's admission agreement with the facility upon admission on 3/5/22. 3/11/24 at 3:51 PM - In response to a written request for R98's admission agreement, E3 (Corporate Clinical Operations) documented, "we do not have" the document. 2. Review of R42's clinical record revealed: 4/22/20 - R42 was admitted to the facility. 12/13/23 - E66 (NP) ordered UA (urinalysis) and C&S (culture and sensitivity) to R/O (rule out) UTI (urinary tract infection). 12/18/23 10:28 AM - Urine culture results	F 842	1.*R98 no longer resides in the facility. *R42, R63, R76, R107, R108 now have their urine culture results filed in the EMR. 2.*All residents have the potential to be affected. *Facility conducted an audit of residents admitted in the past 30 days for completed Admission Agreements. Any missing Admission Agreements were completed. *Facility conducted an audit of residents who had a Urine Culture completed in the past 30 days to determine if results were in the EMR. Missing results were filed in the EMR. 3.*RCA analysis determined the facility lacked backup staff members to complete Admission Agreements when responsible staff is off. The facility trained a backup staff member for this task. *RCA analysis determined facility lacked system to print out urine cultures and place them in the EMR. The facility implemented a system for printing and placing urine cultures in EMR. *Staff Developer/designee will train Unit Clerk on system for printing from laboratory website and placing in EMR. *NHA/designee will audit 100% of new admissions weekly for completion of admission agreements.	

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F 842	Continued From page 63 reported in R42's EMR stated, "Growth- 1 organism growth". R42's EMR did not have readily accessible documentation of the culture results naming the organism and the sensitivities identifying which antibiotic the organism could be treated with. Upon the Surveyor's request, the facility was able to produce a printout from the [laboratory's] website with the 12/15/23 urine culture results, which revealed the organism was Klebsiella oxytoca ESBL (extended-spectrum beta-lactamases). Of note, only a limited number of people have account access to the [laboratory] website. The Surveyor was unable to find evidence of the urine microbiology culture results that showed the organism and sensitivities and documentation of MDRO colonization in R42's EMR . 3. Review of R63's clinical record revealed: 9/22/23 - R63 was admitted to the facility. 12/6/23 - E66 (NP) ordered UA and C&S to R/O UTI. 12/8/23 - Urine culture results reported in R63's EMR stated, "Growth- 1 organism growth". R63's EMR did not have readily accessible documentation of the culture results naming the organism and the sensitivities identifying which antibiotic the organism could be treated with. Upon the Surveyor's request, the facility was able	F 842	*DON/designee will audit 100% of residents' EMR weekly for urine culture results to monitor that are filed in the EMAR. 4.*Audit results will be reported in monthly QA&A meetings until achieving 100% compliance for three consecutive months and PRN as indicated..	

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F 842	Continued From page 64	F 842		

to produce a printout from the [laboratory's] website with the 12/6/23 urine culture results, which revealed the organism was Klebsiella pneumoniae ESBL.

Of note, only a limited number of people have account access to the [laboratory] website.

The Surveyor was unable to find evidence of the urine microbiology culture results that showed the organism and sensitivities and/or documentation of MDRO colonization in R63's EMR .

4. Review of R76's clinical record revealed:

6/5/23- R76 was admitted to the facility.

2/25/24 - E52 (MD) ordered UA and C&S secondary to increased confusion.

2/29/24 - Urine culture results reported in R76's EMR stated, "Growth- 1 organism growth".

R76's EMR did not have readily accessible documentation of the culture results naming the organism and the sensitivities identifying which antibiotic the organism could be treated with.

Upon the Surveyor's request, the facility was able to produce a printout from the [laboratory's] website with the 2/27/24 urine culture results, which revealed the organism was Klebsiella pneumoniae ESBL.

Of note, only a limited number of people have account access to the [laboratory] website.

The Surveyor was unable to find evidence of the

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F 842	Continued From page 65	F 842		

urine microbiology culture results that showed the organism and sensitivities and/or documentation of MDRO colonization in R76's EMR .

5. Review of R107's clinical record revealed:

9/15/23 - R107 was admitted to the facility.

9/25/23 - E12 (NP) ordered UA and C&S to R/O UTI.

9/29/23 - Urine culture results reported in R107's EMR stated, "Growth- 1 organism growth".

R107's EMR did not have readily accessible documentation of the culture results naming the organism and the sensitivities identifying which antibiotic the organism could be treated with.

Upon the Surveyor's request, the facility was able to produce a printout from the [laboratory's] website with the 9/27/23 urine culture results, which revealed the organism was Klebsiella pneumoniae ESBL.

Of note, only a limited number of people have account access to the [laboratory] website.

The Surveyor was unable to find evidence of the urine microbiology culture results that showed the organism and sensitivities.

6. Review of R108's clinical record revealed:

5/10/23 - R108 was admitted to the facility.

1/21/24 - E63 (NP) ordered UA and C&S to R/O UTI.

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F 842	Continued From page 66 1/24/24 - Urine culture results reported in R107's EMR stated, "Growth- 1 organism growth". R108's EMR did not have readily accessible documentation of the culture results naming the organism and the sensitivities identifying which antibiotic the organism could be treated with. Upon the Surveyor's request, the facility was able to produce a printout from the [laboratory's] website with the 1/22/24 urine culture results, which revealed the organism was Klebsiella pneumoniae ESBL. Of note, only a limited number of people have account access to the [laboratory] website. The Surveyor was unable to find evidence of the urine microbiology culture results that showed the organism and sensitivities and/or documentation of MDRO colonization in R108's EMR . 3/12/24 8:35 AM- During an interview, E1 (NHA) stated, "The providers have access to the [laboratory] website to get the names of the organisms. We don't upload the results into the EMR." 3/13/24 3:45 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (Corporate Clinical Operations), E4 (Regional Clinical Specialist) and representatives from the Ombudsman.	F 842		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control	F 880		5/9/24

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F 880	Continued From page 67 The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism	F 880		

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F 880	Continued From page 68 involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which 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; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe and sanitary environment. Findings include: Review of the 4/1/22 facility policy for Glucometers revealed the following: -"Purpose: Disinfection of Blood Glucose Monitoring -Procedure: ...3. Use EPA approved disinfectant	F 880	1.*Once informed by surveyor, E26 was re-educated on how to clean and disinfect a glucometer. 2.*All residents receiving a fingerstick have the potential to be affected. 3.*RCA determined E26 failed to follow the facility's protocol for cleaning and disinfecting glucometers. *Staff Developer/designee will re-educate licensed nurses on how to clean and disinfect a glucometer.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085025	A. BUILDING _____ B. WING _____	C 03/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHURCHMAN VILLAGE	4949 OGLETOWN-STANTON ROAD NEWARK, DE 19713

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F 880	Continued From page 69 to disinfect glucometer per glucometer manufacturer's guidelines." The manufacturers guidelines for cleaning and disinfecting state that the glucometer should be cleaned and disinfected after use on each patient. 3/6/24 7:45AM - During a medication observation, E26 (LPN) obtained a blood glucose level on R27 using a glucometer, E26 did not clean or disinfect the glucometer after using it. At 7:56 AM, E26 obtained a blood glucose reading on R15 using the same glucometer that had not been cleaned or sanitized after it had been used on R27. E26 confirmed the findings at 8:05 AM. 3/13/24 3:45PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (Corporate Clinical Operations), E4 (Regional Clinical Specialist) and representatives from the Ombudsman Office.	F 880	*DON/designee will observe 2 nurses per week cleaning and disinfecting a glucometer. 4.*Audit results will be reported in monthly QA&A meetings until achieving 100% compliance for three consecutive months and PRN as indicated.	
F 940 SS=D	Training Requirements CFR(s): 483.95 §483.95 Training Requirements A facility must develop, implement, and maintain an effective training program for all new and existing staff; individuals providing services under a contractual arrangement; and volunteers, consistent with their expected roles. A facility must determine the amount and types of training necessary based on a facility assessment as specified at § 483.70(e). Training topics must include but are not limited to- This REQUIREMENT is not met as evidenced by: Based on interview and review of facility documentation, it was determined that the facility failed to develop, implement, and maintain an	F 940	1.*E40 has been trained in flushing a nephrostomy tube.	5/9/24

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CHURCHMAN VILLAGE	4949 OGLETOWN-STANTON ROAD NEWARK, DE 19713

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F 940	Continued From page 70 effective training program for staff, consistent with their expected roles. Findings include: Review of the facility Nursing Orientation Check List revealed that nephrostomy (tube placed to drain urine) care was not on the checklist. Review of R296's clinical record revealed: 6/30/23 - R296 was admitted to the facility with multiple diagnoses, including kidney cancer and chronic kidney disease. R296 had a nephrostomy tube placed in his left kidney during a recent hospitalization. R296's left kidney was unable to drain urine because of his kidney cancer. 7/15/23 - A physician's order was written to flush R296's nephrostomy tube with 10 ml saline flush daily, every day shift. R296 was hospitalized seven times from 7/16/23 through 2/28/24, and the facility physician's order for the nephrostomy flush resumed with R296's facility readmissions. 3/7/24 1:30 PM - During an observation E40 (LPN) flushed R296's nephrostomy tube. During an interview, E40 stated that she had not received facility training to flush a nephrostomy tube, but that she was familiar with the procedure from doing it at another facility. 3/7/24 3:24 PM - During an interview E28 (Staff Developer) confirmed that she has not done nephrostomy tube flush education with nursing staff yet. 3/13/24 3:45 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (Corporate Clinical Operations), E4 (Regional Clinical Specialist) and	F 940	2.*All residents with a nephrostomy tube have the potential to be affected. 3.*RCA determined the facility failed to identify the need for licensed nurses to be trained in flushing a nephrostomy tube. *Staff Developer/designee will train staff on how to flush a nephrostomy tube. *DON/designee will observe 2 nephrostomy tubes being flushed weekly. 4.*Audit results will be reported in monthly QA&A meetings until achieving 100% compliance for three consecutive months and PRN as indicated.	

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F 940	Continued From page 71 representatives from the Ombudsman office.	F 940		