STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085035	A. BUILDING _____ B. WING _____	09/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELAWARE HOSPITAL F/T CHRONICALLY ILL (DHCI)	100 SUNNYSIDE ROAD SMYRNA, DE 19977

(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 survey was conducted at this facility from September 3, 2019 through September 10, 2019. The facility census the first day of the survey was 96. During this period an Emergency Preparedness Survey was also conducted by the State of Delaware's Division of Health Care Quality Long Term Care Residents Protection in accordance with 42 CFR 483.73. For the Emergency Preparedness survey, no deficiencies were cited.	E 000		
F 000	INITIAL COMMENTS An unannounced annual survey was conducted at this facility from September 3, 2019 through September 10, 2019. The deficiencies contained in this report are based on observation, interviews, review of residents' clinical records and other facility documentation as indicated. The facility census the first day of the survey was 96. The survey sample totaled forty-four (44). Abbreviations/Definitions used in this report are as follows: ADON - Assistant Director of Nursing; CNA - Certified Nurse's Aide; DON - Director of Nursing; FSD - Food Service Director; NHA - Nursing Home Administrator; RN - Registered Nurse; RNAC - MDS Coordinator; SS - Social Service; SW- Social Worker. Auscultation - to listen to body sounds with a stethoscope; Condenser - an electric machine that produces	F 000		

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

Electronically Signed | 10/14/2019

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 oxygen; Diabetes Mellitus - disease where sugar levels are too high; e.g - for example; e-mail - electronic mail; Gastric tube - tube going directly into the stomach for feeding; Haloperidol - a medication for agitation; IM - intramuscular; Liters - unit of measurement; MAR - Medication Administration Record, list of daily medications to be administered in the Medical Record; manic depression - bipolar disorder - mood disorder; MDS - Minimum Data Set (standardized assessment forms used in nursing homes); mg - milligram, unit of weight; mL - milliliter, unit of liquid measurement; nasal cannula - tube placed into nostrils to deliver oxygen; oxygen saturation - the amount of oxygen in a persons blood; PRN - as needed; Psychosis - loss of contact/touch with reality; repaglinide - an oral blood glucose-lowering drug; schizophrenia - mental disorder with false beliefs of being harmed; severely cognitively impaired - never/rarely made decisions; totally dependent - full staff performance of an activity; Valium - a medication for anxiety; vial - a small glass container for liquid medicines; >- more than; % - percent.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2)	F 550		10/25/19

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F 550	Continued From page 2 §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the	F 550		

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F 550	Continued From page 3 exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of facility documentation it was determined that for three (R31, R81 and R82) out of 44 sampled residents the facility failed to promote care in a manner and environment that maintained or enhanced dignity and respect . Findings include: The facility policy (revised 12/23/16) entitled "Resident Dignity and Quality of Life" included that: -"All nursing staff will have respect for resident's private space and property, e.g.: knocking on doors and requesting permission to enter, waiting for residents that can give permission before entering ..." -"All nursing staff shall conduct themselves in a manner that promotes resident independence and dignity in dining." 1. Review of R82's clinical record revealed: 10/23/15 - R82 was admitted to the facility. 7/26/19 - An annual MDS assessment documented that R37 was severely cognitively impaired and totally dependent on staff for eating. 9/3/19 12:10 PM - A lunch observation in the Candee 3 dining/activity room revealed E8 (CNA) feeding R82 who was in a recliner chair. R82 was in a reclined position with his/her back against the table. There were two other residents at R82's table sitting face forward toward the table while being fed by staff. All other residents at the other four dining tables were sitting face forward toward	F 550	Item 1 A. The facility failed to promote care in a manner that maintained or enhanced dignity and respect for R82. The facility immediately corrected this deficient practice by repositioning R82 to face forward towards the table while being fed by staff. All nursing staff will receive a refresher in-service on proper positioning of residents while being fed by the Director of Nursing (DON) and Training Administrator II or designees. B. All residents in the facility have the potential to be affected by this deficient practice. A sweep of care plans for the residents utilizing reclining chairs for meals was completed on 9/20/19 to ensure their dignity is being maintained during meal times. C. The root cause of this deficient practice is a knowledge deficit related to the requirement that a C.N.A. caring for the resident must position residents in reclining chairs in a manner that promotes resident independence and dignity in dining. All nursing staff will be in-serviced by the Director of Nursing (DON) and Training Administrator II or designees regarding appropriate positioning of residents to face forward towards the table while being fed by staff, by October 25, 2019.	

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F 550	Continued From page 4 the table. 9/3/19 12:20 PM - During an interview (away from residents), the surveyor explained to E8 (CNA) that not facing the table was undignified. E8 then turned R24's chair around to face the table while being fed. 9/3/19 12:30 PM - During an interview, E6 (RN, Unit Manager) confirmed that positioning R82 not facing the table while being fed was undignified. 2. The following was observed from the hallway outside of the room. During an observation on 9/5/19 at 10:20 AM E21 (Maintenance) entered the room of R31 and R81 while they were in the room without knocking. E21 left the room and then reentered the room without knocking. Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON) and E4 (Director) on 9/10/19 during the exit conference, beginning at approximately 2:50 PM.	F 550	D. The Unit Managers will conduct daily observation rounds to ensure that residents are properly positioned face forward towards the table during meals, using the Nursing Services Audit Tool (Attachment 1). The Continuous Quality Improvement Nurse (CQI RN III) or designee will complete random weekly audits of all residents to ensure that they are positioned face forward towards the table while being fed by staff, to ensure 100 percent compliance for 10 consecutive weeks. Thereafter, random audits will continue on a monthly basis. The results of these audits will be reviewed at the monthly QAPI Committee meetings. If it is determined that 100 percent compliance is achieved for 4 consecutive months, then we will conclude that we have successfully addressed the cited deficient practice. Item 2 A. The facility failed to promote care in a manner that maintained or enhanced dignity and respect for R31 and R81. R31 and R81 were not negatively impacted as a result of the cited deficient practice. Once the facility was notified of the deficient practice, staff were given reminders to knock on doors, request permission to enter, and wait for residents that can give permission before entering to ensure that residents privacy and property are respected. Additionally, all staff will receive a refresher in-service by October 25, 2019 on the importance of knocking on doors, requesting permission to enter, and waiting for residents that can	

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F 550	Continued From page 5	F 550	respond, to give permission before entering. B. All residents in the facility have the potential to be affected by this deficient practice of failing to knock on doors, request permission to enter, and wait for permission before entering. The Director of Nursing (DON), Trainer Educator II or designee will conduct a refresher in-service for all staff by October 25, 2019 on the importance of knocking on doors, requesting permission to enter, and waiting for residents that can respond, to give permission before entering. C. The root cause of this deficient practice is a failure to follow the facility policy, Resident Dignity and Quality of Life. This was an isolated incident and not a facility practice. The Unit Managers and Nursing Supervisors will conduct observation rounds to ensure that residents□ dignity is maintained. By October 25, 2019, the Director of Nursing (DON), Trainer Educator II or designee will conduct a refresher in-service on facility policy, Resident Dignity and Quality of Life which includes the correct procedures on knocking on doors, requesting permission to enter, and waiting for residents that can respond, to give permission before entering. D. The Unit Managers and Nursing Supervisors will conduct daily observation rounds to ensure that staff are knocking on doors, requesting permission to enter, and waiting for residents that can	

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F 550	Continued From page 6	F 550	respond, to give permission before entering. Any deficient findings will be immediately addressed and forwarded to the Director of Nursing (DON) for appropriate corrective action. Additionally, the Continuous Quality Improvement Nurse (CQI RN III) or designee will complete random weekly observations using the Nursing Services Audit Tool (Attachment 1), to ensure 100 percent compliance for 10 consecutive weeks. Thereafter, random audits will continue on a monthly basis. The results of these audits will be reviewed at the monthly QAPI Committee meetings. If it is determined that 100 percent compliance is achieved for 4 consecutive months, then we will conclude that we have successfully addressed the cited deficient practice.	
F 584 SS=C	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.	F 584		10/25/19

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F 584	Continued From page 7 (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; §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 record review it was determined that for five (Candee 1, Candee 2, Candee 3, Candee 4 and Candee 5) out of five units the facility failed to provide a clean, homelike environment. Findings include: 1. A letter provided by E1 (NHA) revealed that on 8/8/18 the facility received a proposal to "prepare existing floor tile and install...flooring system...of the entire Candee 100 wing." Observations were made during the initial pool on 9/3/19 from 8:30 AM - 4:30 PM and on 9/10/19	F 584	Item 1 A. The facility failed to provide a clean, homelike environment for five out of five nursing units. Observations of multiple rooms, hallways, and nursing units revealed that there were several different colors, shades, and types of floor tiles installed throughout the building. The facility had already self-identified the need of creating a homelike environment for our residents. Our division had requested and was granted funding through the Civil	

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F 584	Continued From page 8 from 12:10 PM - 12:30 PM of several different colors, shades and types of floor tiles installed throughout the building. These various colors, shades and types were installed in the same room or hallway resulting in a number of rooms and hallways having several different tiles in one location. Observations of this occurred in: Rooms 124, 128, 132, 202, 263, 259, 264, 301, 304, 357, 502, hallways between rooms 414 and 417, 418 and 420, 425 and 427, and hallways on Candee 5. 2. Observations were made during the initial pool on 9/3/19 from 8:30 AM - 4:30 PM of the nurse's stations on Candee 100 and Candee 400 being large and having a glass barrier on top separating the residents from the nursing staff. 3. The following observations were made of the facility being unclean: -Rust was on the wall, near the floor under the sinks in the following rooms: 130, 202, 206 and 304. -The walls were dirty in the following rooms: 113, 130, 206, 207, 208 and 306. -The privacy curtain was ripped in room 208. -The bathroom near room 409 had dusty vents. Findings were reviewed with E1 (NHA), E16 (SS) and E18 (Maintenance) on 9/10/19 from 9:37 AM - 9:56 AM. During interviews at the same time, E1 revealed that Candee 100 would be renovated and plans were put on hold due to the necessity to move all of the residents on this unit to another part of the building while renovations occurred, residents from another facility possibly moving in, and the survey process occurring. The Candee 1 and Candee 4 nurse's stations design was	F 584	Monies penalty fund (CMP) to support a physical plant assessment which will identify what is needed to create a homelike environment. In addition, the facility is collaborating with the University of Delaware□s Civil and Environmental Engineering Department to discuss ways we can address the environmental concerns including replacing the flooring in the entire facility. B. All residents have the potential to be affected by the deficient practice of the facility failing to maintain an environment that is clean, comfortable, and homelike. The facility is currently engaged in collaborative efforts through the CMP grant and the University of Delaware□s Civil and Environmental Engineering Department in addressing environmental concerns including the replacement of flooring in the entire facility. C. The root cause of the deficient practice was a failure for the facility to provide a homelike environment that is clean and comfortable. The facility has since self-identified the need of creating a homelike environment for our residents. The Division requested and was granted funding through the CMP fund to support a physical plant assessment which will identify what is needed to create a homelike environment. In addition, the facility is collaborating with the University of Delaware□s Civil and Environmental Engineering Department to discuss ways we can address the environmental concerns including replacing the flooring	

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F 584	Continued From page 9 chosen by the nursing staff with the intention of infection control. The dirty walls, rust and curtain were corrected immediately or put on the schedule to be corrected. Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON) and E4 (Director) on 9/10/19 during the exit conference, beginning at approximately 2:50 PM.	F 584	in the entire facility. The environmental scan will assist in procuring a review of the physical plant of the facility to make recommendations for optimization of a therapeutic, clean, and homelike environment. The facility will use the combined assessments of the physical plant and facility practices to craft budget requests and improvement plans. D. The Nursing Home Administrator (NHA) will meet with the consulting firm responsible for completing the physical plant assessment monthly to monitor the progress of the environmental assessment. Additionally, the NHA will meet with the consulting engineer monthly to obtain updates on the physical plant assessment of the facility. Once completed, the NHA will engage in discussions with the Division and other stakeholders in obtaining the capital funding budget for the renovation projects in the entire Candee building, which will include the replacement of the flooring. The NHA will present the findings at the quarterly QAPI Steering Committee meetings. Once the funding has been allocated and the renovation projects have been completed, then we will conclude that we have successfully addressed the cited deficient practice. Item 2 A. The facility failed to provide a clean, homelike environment for two out five nursing units. Observations of the nurse□s stations on Candee 100 and	

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F 584	Continued From page 10	F 584	Candee 400 revealed that they are large and have a glass barrier on top separating the residents from the nursing staff. Immediate corrective action was taken by initiating a work order number (Attachment 2) in the Asset Inventory Management (AIM) work order system to resolve the concern. A contracted agency was hired to remove the glass barriers at the Candee 100 and Candee 400 nursing stations. A written contract was developed and approved by the Division of Management Services (DMS) for the removal of the glass barriers on October 3, 2019. (Attachment 2). B. All residents have the potential to be affected by the deficient practice of the facility failing to promptly maintain an environment that is clean, comfortable, and homelike. The Division of Management Services (DMS) Facility Operations staff immediately checked all remaining nurse□s stations to ensure that they did not have a glass barrier on top separating the residents from the nursing staff. C. The root cause of this deficient practice was lack of an established system and procedures regarding the architectural planning and designing of the nurse□s stations in the Candee building. The contracted agency will remove the glass barriers by October 25, 2019. Moving forward, a multidisciplinary approach will be taken with remodeling any nurse□s stations in the Candee building.	

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F 584	Continued From page 11	F 584	D. The Nursing Home Administrator (NHA) will ensure that all glass barriers are removed by October 25, 2019. Moving forward, a multidisciplinary approach will be taken with the remodeling of any nurse□s stations in the Candee building. Additionally, any new remodeling projects will be discussed and reviewed by the QAPI Steering Committee before any changes are made. If it is determined that 100 percent compliance is achieved by the removal of the glass barriers, then we will conclude that we have successfully addressed the cited deficient practice. Item 3 A. The facility failed to provide a clean, homelike environment for five out five nursing units. Observations were made including rust on the walls and near the floor and under the sinks in rooms 130, 202, 206, and 304. The walls were observed to be dirty in rooms 113, 130, 206, 207, 208, and 306. Additionally, the privacy curtain was ripped in room 208 and there were rusty vents in the bathroom near room 409. Corrective actions were taken by initiating work order numbers (Attachment 3) in the Asset Inventory Management (AIM) work order system to resolve the rust concerns. In addition, the dirty walls were immediately cleaned and the privacy curtain in room 208 was immediately replaced. The Division of Management Services (DMS) Facility Operations staff are painting walls and baseboards in the identified rooms	

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F 584	Continued From page 12	F 584	with rust on the walls and near the floors, which will be completed by October 25, 2019. B. All residents have the potential to be affected by the deficient practice of the facility failing to promptly maintain an environment that is clean, comfortable, and homelike. Corrective actions were taken by the DMS Facility Operations staff by checking all residential areas for similar rust and vents to ensure a clean safe homelike environment. Additionally, Housekeeping staff checked all rooms for similar dirty walls and tears in privacy curtains. C. The root cause of this deficient practice was a lack of an established system and procedures for conducting environmental inspections. The Risk Manager/Safety Officer or designee will conduct monthly environmental inspections of all residential, common areas and hallways using the Environmental Checklist (Attachment 4). Additionally, the DMS Facility Operations staff will perform random environmental rounds and will conduct quarterly inspections of all resident care areas. In addition, the Housekeeping Superintendent or designee will complete bi-weekly inspections of all resident rooms. Any privacy curtains found with tears will be removed and replaced. All environmental findings will be promptly addressed and communicated to staff, residents, and the Nursing Home Administrator (NHA).	

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F 584	Continued From page 13	F 584	D. The DMS Facility Operations Superintendent and Housekeeping Superintendent or designees will verify that all environmental concerns identified during the environmental rounds and inspections are addressed promptly and accurately for (8) consecutive weeks. Any environmental concerns that are not addressed will be communicated to the NHA and Social Services Chief Administrator for follow-up and to ensure timely completion. To ensure completeness and sustainability, the Continuous Quality Improvement Nurse (CQI RNIII) will complete an audit of 50 percent of the environmental checklists for (3) consecutive months. All audit results will be submitted to the NHA and Quality Assurance Department and the results will be reviewed at the monthly QAPI committee meetings. If 100 percent compliance is not achieved, then the NHA or designee will meet with the DMS Facility Operations Superintendent and Housekeeping Superintendent or designees to determine the plan of action moving forward. If it is determined that 100 percent compliance is achieved, then we will conclude that we have successfully addressed this cited deficient practice.	
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.	F 641		10/25/19

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F 641	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for two (R55 and R72) out of 24 residents sampled for investigations, the facility failed to ensure the accuracy of MDS assessments. Findings include: 1. Review of R55's clinical record revealed: 12/8/16 - R55 was admitted to the facility. 11/16/17 - Notification of Level 1.5 PASRR Quality Assurance Review by the State Mental Health Authority determined that R55 had "a documented serious mental illness ...[R55] has a mental health history of Bipolar Disorder ..." 7/5/19 - An annual MDS assessment incorrectly documented that R55 was not considered by the state level II PASRR process to have a serious mental illness and/or intellectual disability or related condition. The same MDS assessment documented that R55 had an active diagnosis of manic depression (bipolar disorder) which is considered by the state PASRR to be a serious mental illness. 9/5/19 11:00 AM - During an interview, E11 (SW) confirmed the above MDS error and that E11 would notify E10 (RNAC). 9/10/19 10:00 AM - During an interview, E10 (RNAC) confirmed the MDS error. 2. Review of R72's clinical record revealed: 2/23/17 - R72 was originally admitted to the facility.	F 641	Item 1 A. The facility failed to ensure accuracy of the MDS assessment for R55. The Notification of Level II PASRR Quality Assurance Review by State Mental Health Authority determined that R55 had a documented serious mental illness and/or intellectual disability or related condition. However, the annual MDS incorrectly documented that R55 was not considered by the State Level 2 PASRR process to have a serious mental illness and/or intellectual disability or related condition. The corrected MDS for R55 was submitted (Attachment 5) by the Registered Nurse Assessment Coordinator (RNAC) on 09/23/2019. B. All residents in the facility have the potential to be affected by this deficient practice. A sweep of all residents□ MDS□s with a Level II PASRR Determination Review by the State Mental Health Authority were reviewed for accuracy and revised to reflect appropriate MDS coding in Section A #1500. C. The root cause of this deficient practice is a knowledge deficit related to correct coding for residents with serious mental illness and/or intellectual disability or related conditions. The RNAC□s, Social Services, and Nursing Administrative staff were in-serviced on 9/26/19 by the Delaware Division of	

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F 641	Continued From page 15 7/28/17 - Level II PASRR Determination Review by the State Mental Health Authority determined that R72 had "a documented serious mental illness..." 7/19/19 - An annual MDS assessment incorrectly documented that R72 was not considered by the state level II PASRR process to have a serious mental illness and/or intellectual disability or related condition. The MDS assessment documented that R72 had an active diagnosis of Schizophrenia which is considered by the state PASRR to be a serious mental illness. 9/10/19 10:00 AM - During an interview, E10 (RNAC) confirmed the MDS error. Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON) and E4 (Director) on 9/10/19 during the exit conference, beginning at approximately 2:50 PM.	F 641	Medicaid and Medical Assistance (DMMA) Kent and Sussex Supervisor and PASRR nurse for the Long Term Care Medical Unit for proper coding of residents with Level II PASRR determinations. In response to this citation, DHCI has revised their MDS completion and submission process related to Section A #1500. Prior to the MDS due date, the Hospital Social Services Administrator II or designated Senior Social Worker/Case Managers will complete a review of the Level II PASRR Determination to ensure that Section A #1500 of the MDS is coded correctly. D. The RNAC will validate any changes in the MDS coding for Section A #1500 for accuracy prior to submission. The Continuous Quality Improvement Nurse (CQI RN III) or designee will conduct weekly audits of Section A #1500 of the annual MDS for accuracy of coding related to serious mental illness and/or intellectual disability or related conditions for (10) consecutive weeks. If 100 percent accuracy is not achieved, then the Director of Nursing (DON) or designee will determine the need for additional training related to accurate MDS coding. We will then transition the audit to 100 percent of the annual MDS assessments specific to Section A #1500 for (3) consecutive months. The results of this review will be reported at the monthly QAPI Committee meetings. If the audits indicate that we have sustained 100 percent compliance for (3) consecutive months, then the facility will conclude that we have	

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F 641	Continued From page 16	F 641	successfully addressed this deficient practice. Item 2 A. The facility failed to ensure accuracy of the MDS assessment for R72. The Notification of Level II PASRR Quality Assurance Review by State Mental Health Authority determined that R72 had a documented serious mental illness and/or intellectual disability or related condition. However, the annual MDS was incorrectly documented that R72 was not considered by the State Level 2 PASRR process to have a serious mental illness and/or intellectual disability or related condition. The corrected MDS for R723 was submitted (Attachment 5) by the Registered Nurse Assessment Coordinator (RNAC) on 09/23/2019. B. All residents in the facility have the potential to be affected by this deficient practice. A sweep of all residents□ MDS□s with a Level II PASRR Determination Review by the State Mental Health Authority were reviewed for accuracy and revised to reflect accurate MDS coding in Section A #1500. C. The root cause of this deficient practice is a knowledge deficit related to correct coding for residents with serious mental illness and/or intellectual disability or related conditions. The RNAC□s, Social Services, and Nursing Administrative staff were in-serviced by the Delaware Division of Medicaid and	

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F 641	Continued From page 17	F 641	Medical Assistance (DMMA) Kent and Sussex Supervisor and PASRR nurse for the Long Term Care Medical Unit on 9/26/19 for proper coding of residents with Level II PASRR determinations. In response to this citation, DHCI has revised their MDS completion and submission process related to Section A #1500. Prior to the MDS due date, the Hospital Social Services Administrator II or designated Senior Social Worker/Case Managers will complete a review of the Level II PASRR Determination to ensure that Section A #1500 of the MDS is coded correctly. D. The RNAC will validate any changes in the MDS coding for Section A #1500 for accuracy prior to submission. The Continuous Quality Improvement Nurse (CQI RN III) or designee will conduct weekly audits of Section A #1500 of the annual MDS for accuracy of coding related to serious mental illness and/or intellectual disability or related conditions for (10) consecutive weeks. If 100 percent accuracy is not achieved, then the Director of Nursing (DON) or designee will determine the need for additional training related to accurate MDS coding. We will then transition the audit to 100 percent of the annual MDS assessments specific to Section A #1500 for (3) consecutive months. The results of this review will be reported at the monthly QAPI Committee meetings. If the audits indicate that we have sustained 100 percent compliance for (3) consecutive months, then the facility will conclude that we have	

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F 641	Continued From page 18	F 641	successfully addressed this deficient practice.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §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 - (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	F 656		10/25/19

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F 656	Continued From page 19 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. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R89) out of 24 residents sampled for investigations, the facility failed to develop and implement a comprehensive care plan to include R89's oxygen use. Findings include: Review of R89's clinical record revealed: 9/14/10 - R89 was admitted to the facility. 9/2/19 - A physician's order was written to administer oxygen 2.0 liter/min (per nasal cannula) [to keep oxygen saturation] > or equal to 92% PRN. 9/3/19 12:47 PM - An observation in the Candee 3 dining/activity room revealed that R89 was receiving oxygen via nasal cannula. 9/9/19 2:00 PM - Review of R89's current care plan revealed no reference to respiratory problems or the use of oxygen. 9/9/19 2:00 PM - During an interview, E7 (RN, Supervisor) confirmed the above finding and stated that a respiratory problem would be added to R89's care plan. Findings were reviewed with E1 (NHA), E2	F 656	A. The facility failed to develop and implement a comprehensive care plan to include R89□s oxygen use. The deficient practice was immediately corrected by updating R89□s Care Plan to include a short term care plan to address oxygen therapy. All nurses will receive a refresher in-service by the Director of Nursing (DON) or designee on creating short term care plans by October 25, 2019. B. All residents receiving oxygen therapy have the potential to be affected by the deficient practice of failing to create a short term care plan to address oxygen therapy. A sweep of all residents on oxygen therapy was completed on 9/20/19 to ensure oxygen therapy was addressed in their comprehensive care plan or a short term care plan had been initiated to address the resident□s medical need. C. The root cause of this deficient practice is failure of a nurse to follow the facility□s policy and procedures related to the initiation of a care plan for oxygen therapy for R89. This was an isolated incident and not a standard of practice. All licensed nursing staff will be in-serviced by the Director of Nursing (DON) and	

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F 656	Continued From page 20 (DON), E3 (ADON) and E4 (Director) on 9/10/19 during the exit conference, beginning at approximately 2:50 PM.	F 656	Trainer Educator II or designee by October 25, 2019, regarding the initiation of short term care plans. D. The Unit Manager or designees will review all new physician orders daily to ensure that care plans have been initiated for residents with new oxygen therapy orders. The Continuous Quality Improvement Nurse (CQI RN III) will conduct weekly audits to ensure care plans have been initiated for residents with new oxygen therapy orders, using the Nursing Services Audit Tool (Attachment 1). These audits will be completed for (10) consecutive weeks with 100 percent compliance for residents with new oxygen therapy orders, and thereafter on a monthly basis for (4) consecutive months. The results of these audits will be reviewed at the monthly QAPI Committee meetings. If it is determined that 100 percent compliance has been achieved for (4) consecutive months, then we will conclude that we have successfully addressed the cited deficient practice.	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the	F 657		10/25/19

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F 657	Continued From page 21 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 three (R16, R25 and R27) out of 24 residents sampled for investigations, the facility failed to ensure that care plans were developed by the IDT (Interdisciplinary Team). Findings include: 1. Review of R16's clinical record revealed: 5/31/19 - A quarterly MDS assessment was prepared with an observation end date of 5/31/19. 9/4/19 - The page entitled "Care Plan Signatures" revealed that no food and nutrition services staff signed R16's care plan, indicating participation in the IDT meeting. 2. Review of R25's clinical record revealed:	F 657	A. The facility failed to ensure that care plans were developed by the IDT (Interdisciplinary Team) for three residents (R16, R25 and R27). A member of the food and nutrition services department failed to sign the care plan for R16, R25 and R27, which would indicate attendance at the resident□s IDT meeting. This was an isolated event and not a facility practice. The Hospital Administrator I immediately notified appropriate food and nutrition staff that they must sign all resident care plans during IDT meetings. B. All residents in the facility have the potential to be effected by this deficient practice of developing care plans by the Interdisciplinary Team. The food and nutrition services staff failed to sign R16,	

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F 657	Continued From page 22 6/14/19 - An annual MDS assessment was prepared with an observation end date of 6/14/19. 6/26/19 - The page entitled "Care Plan Signatures" revealed that no food and nutrition services staff signed R25's care plan, indicating participation in the IDT meeting. 3. Review of R27's clinical record revealed: 6/14/19 - An annual MDS assessment was prepared with an observation end date of 6/14/19. 6/26/19 - The page entitled "Care Plan Signatures" revealed that no food and nutrition services staff signed R27's care plan, indicating participation in the IDT meeting. 9/9/19 at approximately 3:20 PM - An interview with E7 (Nursing Supervisor) revealed that he/she did not know why R16's, R25's or R27's care plan was not signed by a food and nutrition staff, but that he/she would investigate. 9/10/19 at 10:07 AM - An interview with E7 confirmed that no food and nutrition staff signed R16's, R25's or R27's care plans. Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON) and E4 (Director) on 9/10/19 during the exit conference, beginning at approximately 2:50 PM.	F 657	R25 and R27 care plan, indicating participation in the IDT meeting. C. The root cause for this deficient practice is a knowledge deficit regarding the regulation. The food and nutrition services department has identified additional employees qualified to attend the IDT meetings. The facility□s Hospital Administrator I will ensure that a member of the food and nutrition services department attends all scheduled IDT meetings to ensure their participation in the development of care plans. Additionally, the Hospital Administrator will review the care plan signature sheets weekly to ensure the participation of all require staff at the IDT meetings, including a staff member of the food and nutrition services department. D. The Hospital Administrator I or designee will conduct weekly audits of all residents□ care plan signature sheets for 10 consecutive weeks with 100 percent compliance and thereafter on a monthly basis for (4) consecutive months to ensure that all required staff members are represented at the weekly care plan (IDT) meetings, including staff from the food and nutrition services department . The results of these audits will be reviewed at the monthly QAPI Committee meetings. If it is determined that 100 percent compliance is achieved for (4) consecutive months, then we will conclude that we have successfully addressed the cited deficient practice.	

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F 684	Continued From page 23	F 684		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, interview and review of other facility documentation it was determined that for one (R14) out of one resident reviewed for medication administration the facility failed to follow physician orders, facility policy and the care plan for refusal of medications. Findings include: Medication Administration Policy, last revised 2/14/18, listed: V. Procedure D. Refusal of medication and or treatment 1. Assess reason for refusal. Make resident aware of consequences of refusals to the best of his/her ability to understand and to foster compliance with medication/treatment plan. 2. Explore alternate measures. Re-approach residents at least five minutes after refusal for another attempt at medication or treatment administration. Resident refusal of medication or treatment for	F 684	A. The facility failed to follow physician orders, facility policy and the care plan for refusal of medications for R14. The facility immediately offered medication education to R14 regarding the importance of taking her medication as prescribed by the Physician. The resident agreed to take her medication with her meals, not before. A new Physician Order was obtained to allow medication to be administered per resident□s preference, medication education was documented and R14□s care plan was updated to reflect resident□s preferences. B. All residents have the potential to be affected by the deficient practice of failing to follow physician orders, facility policy, and the care plan, for refusal of medications. A review of all residents Medication Administration Records were conducted to ensure that no other resident was affected by this deficient practice.	10/25/19

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F 684	Continued From page 24 more than three (3) consecutive days should be reported to the physician/nurse practitioner and addressed at the Interdisciplinary Team Meeting. 7. Document in the Nurses' notes: a. Any observed adverse effects of not receiving medication or treatment. Policy and Procedure Number: 1800 Resident Refusals, last revised 2/15/18, listed: V. Procedure / Responsibilities: A. Upon admission, quarterly, annually, and as needed, the resident will be assessed by the interdisciplinary team for preferences in aspects of care (e.g., feeding bathing, toileting, medication administration, etc.) schedules, activity, and when practicable, room location in the facility. The preferences will be documented in and implemented according to the care plan. In the event the resident is unable to communicate, the wishes of the primary family decision-maker or guardian will be assessed, documented, and implemented. Review of R14's clinical record revealed: 3/13/19 - A physician order and the MAR documented Repaglinide 2 mg take one tablet by mouth three times a day in the morning, afternoon, and evening for type 2 diabetes mellitus with administration instructions to take prior to each meal. Breakfast service time for the resident is 7:30 AM.	F 684	C. The root cause of this deficient practice is a failure to follow facility policy regarding medication administration and the standard of nursing practice. The Director of Nursing (DON), Trainer Administrator II or designee will provide a refresher in-service to all licensed staff regarding the policy on medication administration, the importance of following physician orders, documenting resident□s preferences and refusals and updating care plans by October 25, 2019. D. The Unit Manager, Nursing Supervisor or designee will do weekly medication administration (med pass) audits, to ensure that residents are receiving their medications as prescribed by the Physician, using the Nursing Services Audit Tool (Attachment 1). These audits will be completed for (10) consecutive weeks until 100 percent compliance is obtained. Thereafter, the Continuous Quality Improvement Nurse (CQI RNIII) will conduct random audits of medication administration (Med Pass) to include all med carts on a monthly basis for (4) consecutive months. The results of these audits will be reviewed at the monthly QAPI Committee meetings. If it is determined that 100 percent compliance is achieved for (4) consecutive months, then we will conclude that we have successfully addressed the cited deficient practice	

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F 684	Continued From page 25 Review of R14's care plan, last updated 9/3/19, indicated under Behavior "the potential to become anxious, depressed with intermittent psychosis congruent (in harmony with) with my mood." Approaches included "identify what is triggering or causing the behaviors ... arguments with others altered thought process, and need nurses to administer medications as ordered." Basic Care Needs "can't complete my cares on my own. I need my nurses to assess my functional level, monitor my medication use, and request referrals for me as needed. I need you to speak to me slowly and clearly and offer me simple instructions when you are trying to educate me." September 2019 - The MAR documented the times Repaglinide was administered anywhere between 8:09 AM to 8:52 AM, not prior to breakfast. During a medication administration observation on 9/5/19 at 8:25 AM, R14 was given the Repaglinide after R14 had already eaten most of his/her breakfast. R14 did not receive the medication per order. During an interview, at the same time, with E5 (RN), it was revealed that R14 refused to take the medication when offered earlier. E5 further revealed that R14 refuses to take medication first thing in the morning and does not want to take then until later. Review of the care plan and progress notes lacked evidence of R14's refusal to take medication prior to a meal, but instead was taking medication during or after eating the meal. There was also no evidence that the doctor was aware that the medication was not being administered	F 684		

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F 684	Continued From page 26 as ordered. During an interview with E17 (Unit Manager), on 9/10/19 in the afternoon, revealed there was no evidence of any documentation or education provided to R14 related to not taking the medication as ordered by the physician. Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON) and E4 (Director) on 9/10/19 during the exit conference, beginning at approximately 2:50 PM.	F 684		
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 observation, interview, record review and review of facility policies, it was determined that the facility failed to ensure that respiratory care was provided in a manner consistent with professional standards for one (R89) out of two sampled residents reviewed for respiratory care. The facility failed to provide oxygen services with safe handling and cleaning of respiratory equipment for R89. Findings include: The facility policy (revised 2/16/18) entitled "Oxygen/ Compressed Gas Cylinders Safety"	F 695	A. The facility failed to ensure that respiratory care was provided in a manner consistent with professional standards and to provide oxygen services with safe handling and cleaning of respiratory equipment for R89. The nurse failed to label the humidifier bottle with a date. The deficient practice was immediately corrected by disposing of and replacing the unlabeled humidifier bottle and oxygen nasal cannula with labeled ones. All licensed staff will receive a refresher	10/25/19

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F 695	Continued From page 27 included that: "Unless contraindicated, attach pre-filled humidifier bottle, labeled with the resident's name and date, to the oxygen tank or concentrator ..." Review of R89's clinical record revealed: 9/2/19 - A physician's order was written to administer oxygen 2 liters per minute (per nasal cannula) [to keep oxygen saturation] > or equal to 92% PRN. 9/3/19 12:47 PM - An observation in the Candee 3 dining/activity room revealed R89 receiving oxygen with an unlabeled humidifier bottle and oxygen nasal cannula connected to an oxygen concentrator. Without a date, it was unclear when they were last changed, increasing R89's risk for infection. 9/3/19 1:00 PM - During an interview and observation, E6 (RN, Unit Manager) confirmed that R89's oxygen humidifier bottle and nasal cannula were unlabeled. Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON) and E4 (Director) on 9/10/19 during the exit conference, beginning at approximately 2:50 PM.	F 695	in-service by the Director of Nursing (DON) and Training Administrator II or designees on respiratory care that is consistent with professional standards that includes the safe handling, cleaning, and proper labeling of respiratory equipment by October 25, 2019. B. All residents have the potential to be affected by the deficient practice of failing to follow professional standard of practice regarding oxygen therapy. The nurse failed to label the humidifier bottle and nasal cannula connected to an oxygen concentrator for a resident receiving oxygen therapy. A sweep of all oxygen concentrators was completed on 10/1/19 to ensure that all humidifier bottles and nasal cannulas were labeled according to the standard of practice and facility□s policy. C. The root cause of this deficient practice is a failure of following facility□s policy, and the professional standard of nursing practice regarding oxygen therapy (proper labeling of respiratory equipment). All licensed nursing staff will be in-serviced by the Director of Nursing (DON) and Training Administrator II or designees regarding appropriate labeling of oxygen humidifier bottles and nasal cannulas by October 25, 2019. D. The Nursing Supervisors will conduct weekly audits of all residents□ humidifier bottles and nasal cannula using the Nursing Services Audit Tool (Attachment 1), to ensure that respiratory equipment	

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F 695	Continued From page 28	F 695	has been properly labeled for 10 consecutive weeks with 100 percent compliance and thereafter on a monthly basis for (4) consecutive months. The results of these audits will be reviewed at the monthly QAPI Committee meetings. If it is determined that 100 percent compliance is achieved for (4) consecutive months, then we will conclude that we have successfully addressed the cited deficient practice.	
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of	F 755		10/25/19

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F 755	Continued From page 29 receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that for two out of six medication carts reviewed the facility failed to provide pharmaceutical services to meet the needs of each resident by storing expired (Candee 4) and opened and unlabeled medication vials (Candee 5). Findings include: 1. Candee 4 - B cart: 9/6/19 12:50 PM - During a medication cart observation with E23 (LPN), a multi-dose vial of Valium labeled as opened on 4/1/19 was found. A review of the Medication Sign-Out Sheet for this medication revealed 1 mL was given IM to R9 on both 4/1/19 & 7/8/19. The label on the vial and the information on the Medication Sign-Out Sheet both indicated the vial expired on 10/1/19. E23 confirmed the above information. 9/6/19 1:15 PM - E24 (LPN) stated that he/she called the pharmacist who confirmed that once a multi-dose vial was opened it expired in 28 days. The pharmacist instructed staff to discard this vial. 2. Candee 5 - B cart: 9/6/19 2:00 PM - During a medication cart observation with E25 (LPN), two opened and	F 755	A. The facility failed to provide pharmaceutical services to meet the needs of each resident by storing expired and opened unlabeled medication vials for two medication carts on Candee 4 and 5 nursing units. The facility immediately corrected the deficient practice by disposing of the expired and opened unlabeled medication vials from both medication carts. All licensed nursing staff will receive a refresher in-service by the Director of Nursing (DON) and Training Administrator II or designees on properly labeling and disposing of medication vials by October 25, 2019. B. All residents in the facility have the potential to be affected by this deficient practice of failing to provide pharmaceutical services to meet the needs of each resident by storing expired and opened unlabeled medication vials in the medication carts. A sweep of all medication carts was completed on 09/10/19, to ensure that no opened, expired, and unlabeled medication vials were present on the medication carts. C. The root cause of this deficient practice is failure to follow facility□s	

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F 755	Continued From page 30 unlabeled vials of Haloperidol for IM injection were found in R60's medication drawer. E25 confirmed that these vials should have been disposed of and not left in the medication cart. Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON) and E4 (Director) on 9/10/19 during the exit conference, beginning at approximately 2:50 PM.	F 755	medication administration policy and professional standard of nursing practice pharmaceutical services specific to unlabeled medication and storing of expired medication. All licensed nursing staff will receive a refresher in-service by the Director of Nursing (DON) and Training Administrator II or designees on properly labeling, storing and disposing of expired medication vials by October 25, 2019. D. The Nursing Supervisors will conduct weekly audits of the medication carts to ensure that all medication vials have been labeled upon opening and no expired medication vials are present. Using the Nursing Services Audit Tool (Attachment 1), these audits will be conducted for 10 consecutive weeks with 100 percent compliance and thereafter on a monthly basis for 4 consecutive months. The results of these audits will be reviewed at the monthly QAPI Committee meetings. If it is determined that 100 percent compliance is achieved for 4 consecutive months, then we will conclude that we have successfully addressed the cited deficient practice.	
F 842 SS=D	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	F 842		10/25/19

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F 842	Continued From page 31	F 842		

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 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

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F 842	Continued From page 32 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; (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 four (R33, R36, R78 and R82) out of 44 sampled residents the facility failed to ensure that medical records were accurate and complete. Findings include: 9/4/19 - While completing the initial pool record review the following four residents' (R33, R36, R78, R82,) hard charts were found to have no year on two or more pages of the "Vital Signs and Weight Record". Although the month and the day were present for each vital sign and weight entry, it was impossible to determine the year because each side of the form contained 23 lines. For most residents this data was recorded monthly, so multiple years were on each form. Listed below are the times this issue was identified and confirmed with E22 (Unit Clerk).	F 842	A. The facility failed to ensure that medical records were accurate and complete for R33, R36, R78 and R82. The facility immediately corrected this deficient practice by removing hard copies of all vital signs and weights from the residents medical charts and placing them in archived medical records. The facility also verified that the residents weights and vitals are accurately recorded in the Electronic Medical Record (EMR) system, which automatically records the day, month, and year of each entry. All nursing staff will receive a refresher in-service on maintaining medical records that are complete, accurately documented, readily accessible, and systematically organized by October 25,	

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F 842	Continued From page 33 - 9/4/19 9:40 AM - R33 - 9/4/19 10:00 AM - R78 - 9/4/19 12:55 PM - R82 - 9/4/19 1:00 PM - R36 Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON) and E4 (Director) on 9/10/19 during the exit conference, beginning at approximately 2:50 PM.	F 842	2019. B. All residents in the facility have the potential to be affected by this deficient practice of failing to ensure that medical records are accurate and complete. A sweep of hard copies of vital signs and weights from all residents medical charts was completed on 10/2/19 to ensure that they were placed in archived medical records. Additionally, a sweep of all residents weights and vitals recorded in the Electronic Medical Record system was completed on 10/2/19 to ensure that the day, month, and year was recorded accurately on each entry. C. The root cause of this deficient practice is a failure to follow the professional standards of nursing practices related to maintaining medical records on each resident that are complete, accurately documented, readily accessible, and systematically organized. The facility is currently using the Electronic Medical Record system to ensure accuracy in nursing documentation. All nursing staff will be in-serviced by the Director of Nursing (DON) and Training Administrator II or designees on maintaining medical records that are complete, accurately documented, readily accessible, and systematically organized by October 25, 2019. D. The Unit Managers will complete weekly audits of each residents vital signs and weights recorded in the	

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F 842	Continued From page 34	F 842	Electronic Medical Record (EMR) system to ensure that they are complete and accurately documented using the Nursing Services Audit Tool (Attachment 1). These audits will be completed for (10) consecutive weeks with 100 percent compliance and thereafter on a monthly basis for (4) consecutive months. The results of these audits will be reviewed at the monthly QAPI Committee meetings. If it is determined that 100 percent compliance is achieved for (4) consecutive months, then we will conclude that we have successfully addressed the cited deficient practice.	
F 925 SS=F	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on interview, record review and observations on three (Candee 100, Candee 200 and Candee 500) out of five units and in the kitchen the facility failed to maintain an effective pest control program so that the facility was free of pests by having cockroach complaints, work orders and treatment taking place for at least 8 months. Findings include: 4/25/17 (extended through 4/30/20) - The Pest Control Services contract with all state agencies lists as an additional term and condition that "all pests exclusive of wood boring insects are covered under regular service" and "in the event of pest sightings, successful vendor will report	F 925	A. The facility failed to have an effective pest program so that the facility is free of pests on Candee 100, Candee 200 and Candee 500. Immediate corrective action was taken by contacting the facility□s contracted pest control agency to treat all nursing units and residential areas in the Candee building on September 19, 2019. The service contract was revised with the contracted pest control agency to include an increase in the time spent by the exterminator for service from (1) hour to (2.5) hours once per week effective on 9/26/19 (Attachment 6).	10/25/19

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F 925	Continued From page 35 within twenty-four (24) hours and provide at no cost to the State of Delaware unlimited call-back services." 3/19/19 - A proposal from the facility's pest control company detailed a job named "American Roach Treatments" for the facility. Specifications included six treatments of crack and crevice treatment to the kitchen, dish washing room, basement, crawl space and Candee Building crawl space and spraying the exterior of the kitchen. Services were provided on 6/13/19, 7/31/19 and 9/5/19. E-mails reviewed pertaining to pest control revealed: 2/2/19 - There have been issues with roaches in the dietary (kitchen) department including, "employee had one crawl up [his/her] leg." 2/3/19 - The dietary department has a "major problem with roaches." 2/9/19 - The dietary department has not seen the exterminator in weeks and needs treatment. 2/14/19 - The dietary department has a "major problem with roaches. They are swarming around each scrapping station" and were found "in the steamers in the kitchen." 7/9/19 - The dietary department requested that the exterminator "addresses the roaches" in their department. AiM (internal system for maintenance requests) Customer Request Summary Reports reviewed revealed the following: 6/29/19 - The resident in room 134 complained of roaches and bugs in room. 8/6/19 - A request was made to the pest control company in regards to the dietary building having "major roaches again."	F 925	B. All residents have the potential to be affected by the deficient practice of the facility failing to maintain an effective pest control program. The Division of Management Services (DMS) Facility Operations and the contracted pest control agency immediately obtained feedback from all nursing units regarding similar concerns to verify any other areas that require additional treatment. C. The root cause of the deficient practice was the facility□s lack of an effective pest control program. In response to this citation, the time spent by the exterminator for service has been increased from (1) hour to (2.5 hours) once per week. Each week the exterminator will do rounds and inspect for live pests. At each areas of inspections, he will place bug traps with dates of placement in all resident areas that will not be eyesore, and these traps will be replaced each week. Nursing staff will also send emails in our work order system for treatment if any live pests are noticed in any areas of the facility. We now are requiring a signature on a sign-in sheets on each unit to validate that pest control services and inspection of live pests were completed on each scheduled date (Attachment 6). All nursing staff will be in-serviced by the Director of Nursing (DON) and Trainer Educator II or designee on the new process whenever live pests are seen in our facility by October 25, 2019. D. The Risk Manager / Safety Officer or	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085035	A. BUILDING _____ B. WING _____	09/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELAWARE HOSPITAL F/T CHRONICALLY ILL (DHCI)	100 SUNNYSIDE ROAD SMYRNA, DE 19977

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F 925	Continued From page 36 8/9/19 - A request was made to the pest control company in regards to roaches sighted in the Candee 500 dayroom, Candee 500 resident bathroom and room 506. 9/3/19 - The resident in room 134 complained of roaches and bugs in the room. Pest control invoices/inspection reports reviewed revealed the following: 3/14/19 - The company baited for roaches in the main kitchen and dishwashing room. 3/21/19 - The company treated the kitchen areas for roaches. 3/28/19 - The company baited for roach activity in the main kitchen and dishwashing areas. Roach activity had decreased. 4/4/19 - The company treated for roaches in the Candee 500 bathrooms and "put down more ...roach bait throughout the kitchen." 4/11/19 - The company applied roach bait to the main kitchen and dishwashing room. 4/18/19 - The company "put down ...roach bait in the kitchen." 4/26/19 - The company "treated the kitchen with ...roach bait." 5/2/19 - The company "put more roach bait in the kitchen." 5/9/19 - The company "re-baited kitchen area" for roaches. The Candee 100 ceiling was baited for roaches, as a roach was reported in the ceiling. Some American cockroaches were found in the kitchen traps. 5/16/19 - The company treated room 134 for roaches. 5/23/19 - The company reported several American cockroaches were seen in the kitchen and set up more traps in this area. 5/30/19 - The company treated for roaches in rooms 134 through 157.	F 925	designee will accompany the exterminator during his inspection and treatment of live pests in our facility. They will provide documentation that rooms and common areas were inspected and treated for live pests. The Continuous Quality Improvement Nurse (CQI RN III) will conduct weekly audits to ensure signatures have been obtained on the sign-in sheets using the Nursing Services Audit Tool (Attachment 1). These audits will be completed for (10) consecutive weeks with 100 percent compliance, and thereafter on a monthly basis for (4) consecutive months. The results of these audit Electronic Medical Record system s will be reviewed at the monthly QAPI Committee meetings. If it is determined that 100 percent compliance is achieved for (4) consecutive months, then we will conclude that we have successfully addressed the cited deficient practice.	

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F 925	Continued From page 37 6/13/19 - The company "baited for roaches in the kitchen." 6/20/19 - The company "put ...roach bait around in the kitchen." 6/27/19 - The company "inspected kitchen and dietary [and] replaced [American Cockroach] traps as needed." 7/3/19 - The company treated the kitchen for roaches. 7/11/19 - The company noted reports of American cockroaches throughout the dietary department and applied granulated cockroach bait to the dietary department, kitchen and dishwashing room. 7/18/19 - The company "treated for roaches throughout the kitchen." 7/25/19 - The company baited for cockroaches in the kitchen "due to American roach activity." 8/1/19 - The company "treated for roaches throughout the kitchen." 8/9/19 - The company applied granulated cockroach bait in the food service basement. 9/5/19 - The company treated room 134 for roaches. 9/06/19 11:30 AM - During an interview, E14 (FSD) stated, "Yes [there are pests, in the kitchen], but we have weekly pest control." 9/6/19 2:15 PM - During an interview, E15 (Risk Manager) revealed concerns with pest control being ineffective in the facility. 9/10/19 10:00 PM - An observation was made at the entrance to the Candee 200 unit of a large cockroach. E1 (NHA) and E16 (SS) were present at the time and E1 immediately destroyed it. The facility failed to have an effective pest control	F 925		

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F 925	Continued From page 38 program to ensure that the facility is free of pests. Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON) and E4 (Director) on 9/10/19 during the exit conference, beginning at approximately 2:50 PM.	F 925		

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Health Care Quality
Office of Long Term Care Residents Protection

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

STATE SURVEY REPORT

NAME OF FACILITY: Delaware Hospital F/t Chronically Ill (dhci)
DATE SURVEY COMPLETED: September 10, 2019

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 survey was conducted at this facility from September 3, 2019 through September 10, 2019. The facility census the first day of the survey was 96. During this period an Emergency Preparedness Survey was also conducted by the State of Delaware's Division of Health Care Quality Long Term Care Residents Protection in accordance with 42 CFR 483.73. For the Emergency Preparedness survey, no deficiencies were cited.		
3201	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.0			
3201.1.2	**Scope** **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 September 10, 2019: F550, F584, F641, F656, F657, F684, F695, F755, F809, F842,		
Title 16			

Provider's Signature _____ Title LNHA Date 10/15/2019

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NAME OF FACILITY: Delaware Hospital F/t Chronically Ill (dhci)
DATE SURVEY COMPLETED: September 10, 2019

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
Chapter 11 1162	**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 September 10, 2019: F550, F584, F641, F656, F657, F684, F695, F755, F809, F842, and F925. **Nursing Staffing** Based on observation and interview, it was determined that the facility failed to post the titles of the nursing staff assigned to each unit and the nursing supervisor on duty for each shift in the common areas of the three out of five nursing units. Findings include: 1. Nursing staff postings: 9/6/19 - Observations of the common areas of units 300, 400, 500 out of five units revealed that the following required information was not included in the staff postings: - titles of the nurse or nurse supervisors. 9/9/19 - Observations of the common areas of units 200, 400, 500 out five units revealed that the following required information was not included in the staff postings: - titles of the nurse or the nurse supervisor.	each unit and titles of nursing supervisors on duty for each shift. The Nursing Home Administrator and the Chief Social Services Administrator conducted observation rounds on 09/11/19 to ensure compliance. All other nursing units were found to be in compliance. C. The root cause of this deficient practice is a knowledge deficit related to the State regulatory requirement for posting of nursing staffing to include assigned staff names and titles on the nursing units, including names and titles of shift supervisors. All Operation Support Specialists (OSS), Charge Nurses, Unit Managers, and Nursing Supervisors will be in-serviced by the Director of Nursing (DON), and Trainer Administrator II or designees regarding the State's regulatory requirement for posting of names and titles of assigned staff on each nursing unit, including the names and titles of each shift supervisors in the common areas on the nursing units by October 25, 2019. D. The Unit Managers and Nursing Supervisors will conduct daily observation rounds to ensure that assigned staff names and titles are posted on each nursing unit,	

Provider's Signature _____ Title LNHA Date 10/16/19

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NAME OF FACILITY: Delaware Hospital F/t Chronically Ill (dhci)
DATE SURVEY COMPLETED: September 10, 2019

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	During an observation and interview with E16 (Social Service Administrator) on C200 on 9/10/19 at 10:02 AM, it was confirmed the above staffing information was not included in the staff postings and the postings were corrected right away.	including names and titles of shift supervisors. Any deficient findings will be immediately corrected and Nursing Administration will be made aware of the corrective action. Additionally, the Continuous Quality Improvement Nurse (CQI RN III) or designee will complete random weekly observations using the Nursing Services Audit Tool (**Attachment 1**), to ensure 100 percent compliance for 10 consecutive weeks. Thereafter, random audits will continue on a monthly basis for four (4) months. The results of these audits will be reviewed at the monthly QAPI Committee meetings. If it is determined that 100 percent compliance is achieved for four (4) consecutive months, then we will conclude that we have successfully addressed the cited deficient practice. **This requirement is not met as evidenced by:** Cross Refer to the CMS 2567-L survey completed September 10, 2019: F550, F584, F641, F656, F657, F684, F695, F755, F809, F842, and F925.	10/16/2019

Provider's Signature _____ Title LNHA Date 10/16/19

H1-0000973 10/16/19