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

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: Harrison Senior Living

DATE SURVEY COMPLETED: April 21, 2021

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 and complaint survey was conducted at this facility from April 13, 2021 through April 21, 2021. The deficiencies contained in this report are based on observation, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 103. The survey sample totaled forty-six (46). **Regulations for Skilled and Intermediate Care Facilities** **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: direct care per resident for Medicaid eligible reimbursement.**		

Provider's Signature _____ Title _____ Date _____

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	This requirement is not met as evidenced by: Cross Refer to the CMS 2567-L survey completed April 21, 2021: F561 F641 F657 F677 F684 F689 F756 F791 F812 and F880. **Health and Safety Regulatory Provisions Concerning Public Health** **Long-Term Care Facilities and Services.** **Abuse, Neglect, Mistreatment, or Financial Exploitation of Residents or Patients.** **Criminal background checks.** **(a) Purpose. — The purpose of the criminal background check and drug screening requirements of this section and § 1142 of this title is the protection of the safety and well-being of residents of long-term care facilities licensed pursuant to this chapter. These sections shall be construed broadly to accomplish this purpose.** **(c) An employer may not employ an applicant for work in a facility before obtaining a criminal history. The criminal history of any person not employed directly by the facility must be provided to the facility upon the person's commencement of work.** **(d) The requirements of subsection (c) of this section may be suspended for 60 days if the employer wishes to employ the applicant on a conditional basis.** **(1) Before an employer may offer conditional employment, the employer must receive verification that the applicant has been fingerprinted by the SBI for purposes of the criminal history.**	Cross Refer to the Plan of Correction in the 2567-L on 4-21-2021 for F561, F641, F657, F677, F684, F689, F756, F791, and F880. A.) Center cannot retroactively produce BCC check for employee. Background check did not reveal any issues. Employee had payment proof of fingerprinting prior to employment. BCC did not send results to provider, but rather to alternative provider, based on applicant's dual job request. B.) Fingerprinting was done during peak of Covid-19 DE State's changes in government operations. A whole house audit was conducted and only this singular employee had this error. All residents could be affected by this practice. C.) RCA, just prior to survey, determined that center should request updated fingerprints as that BCC could not send or resubmit the original report. Human Resources Director updated process to validate and obtain missing background check within twenty-one days with updated e-mail and phone contacts with BCC. Human Resources Director confirmed with BCC on	May 31, 2021 May 31, 2021

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	Health and Safety Delaware Administrative Code **Criminal History and Drug Testing for Nursing and Similar Facilities** **Definitions** **"Background Check Center (BCC)" means the electronic system which combines data streams from various sources within and outside the State in order to assist an employer in determining the suitability of a person for employment in a nursing facility or similar facility, or home care agency as those terms are defined in the enabling statute. See 29 Del.C. §7972.** **"BCC consent form" means the form provided by DHSS which informs the Applicant of the scope of the BCC, the Applicant's legal obligations, and the legal sanctions for failure to provide complete and accurate information.** **"DHSS" means the Department of Health and Social Services. DHSS owns and operates the BCC.** **"DLTCRP" means the Division of Long Term Care Residents Protection, Department of Health and Social Services. The Division is responsible for background checks for licensed facilities.** **Drug Tests** **The BCC provides an electronic conduit through the Delaware Health Information Network (DHIN) to transmit the results of a drug test from a DHIN participating laboratory to the employer. An employer that chooses not to engage a DHIN-participating laboratory will certify that a drug test has been secured by checking a box in the BCC. If the box is checked, it constitutes a representation that a drug test which complies with statutory requirements, 11**	the process for reconciliation and an audit tool was created as well as a distinct survey binder for rapid review. D.) Human Resources Director and / or Designee will audit all new hires monthly for accuracy in BCC reporting and date of information collection. Audits will be reviewed monthly in QA until 100% compliance is achieved for three (3) consecutive months. A.) Center cannot retroactively enter negative drug test results into Delaware BCC. Employee's Drug Test was negative and collected before employee started working with any Residents. BCC has publicly posted diminished hours and contact during the height of Covid-19. B.) BCC request was made during height of state Covid-19 changes in state operations. A whole house audit was conducted and only this singular employee file had the error, in submission retrieval.	May 31, 2021

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	Del.C. 1142, has been secured prior to hiring. This requirement was not met as evidenced by: Based on review of facility documentation and staff interviews, it was determined that the facility failed to ensure and certify on the BCC website that fingerprinting and/or drug screening was completed for two (E30 and E31) out fifteen (15) staff sampled for pre-employment background checks. Findings include: 4/21/21 3:00 PM - During the exit conference with E1 (NHA), E2 (DON), E3 (ADON), and E6 (MD) it was explained that findings are contingent on BBC review of a sample of staff. 1.E30 (Dietary Aide): 4/21/21 - Review of the State Agency Personnel Audit Form completed by the facility revealed that E30's first day working in the facility was 5/5/20. 4/29/21 – Review of the State of Delaware fingerprint database revealed that E30's fingerprint clearance was not in the State BCC database until 4/24/21 and drug screen was not received by the BCC until 2/3/21. 4/28/21 10:58 AM – E29 (HR Coordinator) submitted an email to the State Agency that confirmed E30 is currently working at the facility, and her first day one the job was actually 5/8/20. Her pre-employment drug screen was completed on 5/5/20 when she accepted the job offer. E29 explained that although the facility believed E30 that was previously fingerprinted, the facility did not verify this with the BCC. After the lack of fingerprints was brought to the facility's attention E29 was sent for fingerprinting on (4/23/21).	C.) RCA, just prior to survey, suggested that all outlying submissions need to be corrected within thirty days and resubmitted for compliance. Human Resources Director confirmed with BCC o the process for reconciliation and an audit tool was created as well as a distinct survey binder for rapid review. D.) Human Resources Director and / or Designee will audit all new hires monthly for accuracy in BCC reporting and date of information collection. Audits will be reviewed monthly in QA until 100% compliance is achieved for three (3) consecutive months	

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	4/28/21 1:24 PM – E29 (HR Coordinator) submitted an email to the State Agency that explained that E30's drug screen was performed at the facility on 5/5/20. Drug screens are interpreted in house and then another manager reviews and verifies the testing results. E29 stated "As to why her drug testing date was entered wrong I am unsure why that happened this is usually entered the same day we do the testing." 2. E31 (CNA): 4/21/21 - Review of the State Agency Personnel Audit Form completed by the facility revealed that E31's first day working in the facility was 9/10/19. 4/29/21 – Review of the State of Delaware BCC database revealed that E31's drug screen was not received by the BCC until 2/3/21. 4/28/21 1:24 PM – E29 (HR Coordinator) submitted an email to the State Agency that explained that E31's drug screen was completed on 8/29/19. E29 continued "When I start here I had never used BCC before, so It's been a learning tool for me. I found several employees where entered in the BCC system but was never completed so I was trying to clean these up and have the system show the actual hired employees and separate from those no longer with us. This is what triggered my audit and have been working on getting it completely updated".		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085029	A. BUILDING _____ B. WING _____	C 04/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRISON SENIOR LIVING OF GEORGETOWN, LLC	110 W. NORTH STREET GEORGETOWN, DE 19947

(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 April 13, 2021 through April 21, 2021. The facility census the first day of the survey was 103. During this period, an Emergency Preparedness survey was also conducted by the State of Delaware Division of Health Care Quality, Office of Long Term Care Residents Protection in accordance with 42 CFR 483.73. For the Emergency Preparedness survey, no deficiencies were identified.	E 000		
F 000	INITIAL COMMENTS An unannounced annual and complaint survey was conducted at this facility from April 13, 2021 through April 21, 2021. The deficiencies contained in this report are based on observation, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 103. The survey sample totaled forty-six (46). ADON - Assistant Director of Nursing; CNA - Certified Nurse's Aide; DON - Director of Nursing; ICP - Infection Control Practitioner; LPN - Licensed Practical Nurse; MD - Medical Doctor; NHA - Nursing Home Administrator; RN - Registered Nurse; RNAC - Registered Nurse Assessment Coordinator; UM - Unit Manager; ADL - activities of daily living;	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/10/2021

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 BIMS (Brief Interview for Mental Status) - test to measure thinking ability with score ranges from 0 to 15. 13-15 Cognitively Intact 8-12 Moderately Impaired 0-7 Severe Impairment CDC - Centers for Disease Control and Prevention; CMS - Centers for Medicare & Medicaid Services; COVID-19/Coronavirus -a respiratory illness that can be spread person to person; Dementia - brain disorder with memory loss, poor judgement, personality changes and disorientation OR loss of mental functions such as memory and reasoning that interferes with a person's daily functioning; Dycem - an anti-slip material used to prevent slipping or falling; e.g. - for example; eMAR - electronic Medication Administration Record; eTAR (electronic Treatment Administration Record) - list of resident treatments that are signed off when completed; etc. - and so on; EMR - Electronic Medical Record; MDS (Minimum Data Set) - standardized assessment used in nursing homes; SARS-Cov-2 - Coronavirus; QA - Quality Assurance; QAPI - Quality Assurance Process Improvement.	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 promote and facilitate resident self-determination through support of resident choice, including but	F 561		5/31/21

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F 561	Continued From page 2 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 and record review, it was determined that for one (R38) out of two residents reviewed for choices, the facility failed to ensure that the resident had the right to choose a schedule for medication administration, consistent with the resident's interest. Findings include: Review of R38's clinical revealed the following: 3/1/21- An admission MDS assessment documented R38 as being able to make decisions independently.	F 561	A.) Center cannot retroactively perform a Resident preference assessment and /or education on medication preference. Upon discovery, Resident met with NP later that day and coordinated medication timing with personal goals. B.) All Residents with the ability for self-determination and have medication administration timing preferences could be affected. A whole house audit was completed along with review of grievances for the past year. There were no	

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F 561	Continued From page 3 During an interview on 4/13/21 at 9:34 AM, R38 was asked, "Are you able to make choices in your daily life that are important to you such as being able to choose when you receive your medications?" R38 responded, "I would love to sleep in, but it doesn't fit their schedule of when they have their workload and when they give the pills. I like to get up when I get up like 10:00 AM." R38 was then asked whether the facility asked what time R38 prefers to be awakened to receive medications and R38 stated, "No". 4/14/21 - Review of R38's medication administration record revealed the following medications scheduled to be administered at 6:00 AM: an iron supplement, thyroid (gland in neck) medication and a medication for heartburn. 4/14/21 - Review of R38's Kardex (document that guides residents care) documented that for R38 "Activities that are important to me are: resting in bed as needed...". During an interview on 4/20/21 at 9:26 AM with E22 (RN), it was confirmed that the facility did not have a system to ensure residents choices were honored regarding preferences for waking up to receive medications. E22 stated "No, we base our medication [administration] timing on the rooms, where they are located in the building, for instance, our main medication administration time is 8:00 AM or 8:00 at night. We don't do it per their [residents] request because then we would be all over the place." E22 was then asked if R38's 6:00 AM medications had to be given at that time, and E22 stated, "I can talk to the Nurse Practitioner and if they agree we can change the times."	F 561	grievances or care plan notes regarding issues of medication timing. Medication preference observation added to admission process. C.) RCA confirmed that there are coordinated timelines for medication administration that has been agreed attending physician and medical director. However, preference confirmation and/or education was not applied upon admission or reviewed with Resident. Medication preference added to admission packet. Education on assessment will be given to all nursing staff and added to new-hire orientation. D.) Unit Manager and / or designee will audit all new admissions that a medication preference and education has been done on all new admissions. Audits will be reviewed monthly in QA until 100% is achieved for three (3) consecutive months	

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F 561	Continued From page 4 4/21/21 3:00 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON), and E6 (MD) during the exit conference.	F 561		
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 observation, record review, and interview, it was determined that the facility failed to have MDS assessments that accurately reflected the residents' status for two (R59 and R75) out of 46 sampled residents for stage two investigations. Findings include: 1. The following was reviewed in R59's clinical record: 4/10/20 - R59 was admitted to the facility with full upper and lower dentures. 9/23/20 - The Quarterly MDS Assessment stated that R59 had broken or loose fitting dentures. 4/15/21 1:12 PM - An interview with E9 (RNAC) revealed that the 9/23/20 MDS assessment incorrectly documented R59 as having broken or loosely fitting dentures. E9 recalled interviewing R59 about his dentures and did not recall any problems. 4/19/21 10:35 AM - A subsequent interview with E9 (RNAC) was conducted regarding the 9/23/20 MDS assessment. E9 was asked while	F 641	A.) Center cannot retroactively change assessments to R59 and R75. Residents R59 and R75 had their MDS updated to reflect findings to match their current assessment. B.) Residents with MDS assessments surrounding dentures, denture history and poor prognosis while receiving Hospice could be affected. A whole house audit was conducted, and no other Residents had inaccurate assessments in these categories. C.) RCA determined that dental assessment was made by Resident verbalization of condition versus actual inspection-based assessment; and Hospice assessment was a keystroke error that was not caught by MDS scrubber. Inservice created for RNAC and Nurses to inspect appliances versus interview and where to double check prognosis for Hospice on MDS. D.) Director of Nursing or Designee will	5/31/21

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F 641	Continued From page 5 conducting the oral health assessment, whether E9 had seen R59's dentures. E9 replied for a cognitively intact resident such as R59, she would ask the resident if the dentures were broken or were loose and would not visually examine the dentures. The facility failed to ensure that the 9/23/20 MDS assessment accurately reflected the status of R59's dentures. 2. R75's clinical record revealed the following: 3/31/21 - R75 was admitted to the facility while continuing to receive hospice services. 4/4/21- An admission MDS assessment documented R75 as receiving hospice care and the poor prognosis segment documented "no." During an interview on 4/15/21 at 1:40 PM, E24 (RN MDS coordinator) confirmed the error to R75's admission MDS assessment regarding a "no" response to the prognosis segment for a hospice resident. 4/21/21 3:00 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON), and E6 (MD) during the exit conference.	F 641	audit all new Hospice and Prognosis MDS Assessment and will review three 3 MDS assessments for dentures and dental appliances for accuracy, weekly. Audits will be reviewed monthly in QA until 100% is achieved for three (3) consecutive months.	
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	F 657		5/31/21

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F 657	Continued From page 6 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 one (R37) out of 46 residents sampled for stage two investigations, the facility failed to review and revise R37's care plan to reflect current physician's orders for aspiration precautions. Findings include: Review of R37's clinical record revealed: 3/5/14 - R37 was admitted to the facility. 12/19/20 - R37's revised ADL care plan documented independence with eating after set up. 6/17/20 - R37's plan of care included risk for	F 657	A.) Center cannot retroactively clarify the physician's order from speech therapist. Order was changed to match current goals and observed status. B.) All residents with aspiration risks with conflicting notes from a speech therapist are at risk. A whole house audit was immediately conducted with speech therapist on all Residents with aspiration risks. Language of therapy orders were clarified to match nursing protocols as observed and physician signed. C.) RCA confirmed that speech therapist was not provided education on nursing	

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F 657	Continued From page 7 aspiration related to difficulty swallowing with an intervention of assistance with all meals. 3/7/21 - R37's physician's orders included aspiration precautions with (one to one) staff supervision with all intake by mouth. R37's care plan was not reviewed and revised to include the increased level of supervision with eating. 4/21/21 Approximately 2:00 PM - During an interview, E2 (DON) confirmed that R37's plan of care included contradictory interventions that did not reflect the physician's most recent order for aspiration precautions for one to one staff supervision with all oral intake. 4/21/21 3:00 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON), and E6 (MD) during the exit conference.	F 657	procedures for aspiration risk during meals; and that nursing did not clarify order as written by Speech therapist to match procedure. All new aspiration orders originating from Speech Therapy will now be written with nursing to confirm accuracy before submitted to physician. D.) Director of Nursing or Designee will audit all new aspiration risk orders to verify accuracy between speech therapy and nursing procedure. Audits will be reviewed monthly in QA until 100% is achieved for three (3) consecutive months.	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that for one (R85) out of three residents reviewed for personal hygiene, the facility failed to provide personal hygiene for a dependent resident. Findings include: Review of R85's clinical record revealed: 3/27/21 - An admission MDS assessment documented R85 as requiring extensive	F 677	A.) Center cannot retroactively perform ADL's on R85. Facial hair shave provided within two hours of discovery. B.) Residents with behaviors and preferences for refusals for ADL care with repeat attempts care plan are at risk. A whole house audit for facial hair maintenance on Residents, with or without behaviors, was conducted and no facial	5/31/21

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	085029	A. BUILDING _____ B. WING _____	C 04/21/2021

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HARRISON SENIOR LIVING OF GEORGETOWN, LLC	110 W. NORTH STREET GEORGETOWN, DE 19947

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F 677	Continued From page 8 assistance of one person for completion of personal hygiene, including shaving. 3/24/21 - A care plan for ADL performance documented that R85 required staff participation with personal hygiene. An additional care plan was created for R85 being resistive to care related to refusing care, medications,and treatment with interventions that indicated if resident resists ADLs, reassure resident, leave and return 5-10 minutes later and try again. During an interview on 4/13/21 at 12:30 PM, R85 stated to surveyor "I'd like to get a shave. I don't have a razor." A significant amount of facial hair was observed. 4/13/21 - Review of the CNA Kardex (guide to resident care) revealed that R85 required staff participation with personal hygiene. The Kardex documented, "if possible, negotiate a time for ADLs so that the resident participates in the decision making process. Return at the agreed upon time. If resident resists with ADLs, reassure resident, leave and return 5-10 minutes later and try again." 4/13/21- 4/15/21- Review of the CNA documentation for behavior monitoring of rejection of care provided no documented refusals of personal hygiene care by R85. 4/14/21 8:48 AM - R85 was observed in a wheelchair in his room eating breakfast unshaven with a significant amount of facial hair. When the surveyor asked if R85 still wanted to be shaved, R85 answered "Yes." 4/15/21 12:09 PM - R85 was observed in bed	F 677	hair issues were found or grievances. C.) RCA confirmed that there was no follow up by C.N.A. at end of shift to determine if care plan approach still worked for outcomes requiring a different approach than in assignment. Policy to change that missed or refused ADL's for residents with care plan for refusals will be reported to nurse before end of shift to reschedule or consider adjustment to care plan. Staff developer to perform in-service. D.) Director of Nursing and/or Designee will audit ten (10) ADL refusals by Residents with care plan of refusing care to verify if reporting is occurring, alternatives have been determined to achieve goals and if care plan requires change. Audits will be reviewed monthly in QA until 100% is achieved for three (3) consecutive months	

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F 677	Continued From page 9 unshaven. During an interview on 4/15/21 at 11:30 AM, E23 (CNA) confirmed R85 had not received a shave during completion of personal hygiene. 4/21/21 3:00 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON), and E6 (MD) during the exit conference.	F 677		
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 observation, interview, record review and review of other facility documentation it was determined that for one (R37) out of 46 sampled residents reviewed in stage two investigation, the facility failed to follow the prescribed plan of care for meal supervision. Findings include: A facility policy entitled Aspiration Precautions (last revised October 2020) included: "Residents who are at risk for aspiration will be identified and provided with necessary care and services to decrease their risk for aspiration. Residents will be monitored during meals to ensure safety and proper interventions are in place."	F 684	A.) Cross-refer to F657. Center cannot retroactively change physician notes from Speech Therapist. Order was reviewed by speech therapist after discovery and amended to match protocol. B.) Residents with aspiration risk are at risk. A whole house audit of all Residents on aspiration risks were identified and orders reviewed. Clarified orders were added with policy language to C.N.A. assignments and Quick Care References for nurses. Education to all clinical staff will be provided by Staff Developer.	5/31/21

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F 684	Continued From page 10 Review of R37's clinical record revealed: 3/5/14 - R37 was admitted to the facility. 6/17/20 - R37's plan of care included risk for aspiration related to difficulty swallowing with an approach of supervised dining with all meals. 2/27/21 - A 5-day MDS documented that R37 had a diagnosis of difficulty swallowing. 3/7/21 - R37 had a physicians's order for aspiration precautions that included one to one supervision with all intake by mouth. 4/15/21 - 11:55 AM, 12:05 PM, 12:34 PM and 12:58 PM - R37 was observed in his room, sitting in his wheelchair, unsupervised with a cup of liquid (drink) on his table within his reach. 4/16/21 12:20 PM - R37 was observed in his room, in his wheelchair, with his lunch tray in front of him, eating large bites of food unsupervised. 4/16/21 12:25 PM - During an interview with E10 (CNA), when asked if R37 needed assistance with his meals, she stated that "No, he feeds himself." 4/16/21 12:30 PM - During an interview with E12 (RN) it was revealed that she did not know if R37 required supervision with his meals, but stated she would check. E12 confirmed that the resident was not being supervised with his meal. Upon returning to the nurse's station, E12 asked E13 (LPN) whether R37 required supervision or had aspiration precautions with his meals. E13 (R37's nurse) stated that she would "Have to look." E13 looked at a sheet of paper and confirmed that	F 684	C.) RCA confirmed, as cross-referred to F657, that order written did not match the procedure and therefore the C.N.A. assignment and the Quick Care References contained unclear information. All new aspiration orders, written by the therapy and nursing team, will be reviewed for format when entered into the EHR for C.N.A. assignments and Quick Care Reference guide. D.) Director of Nursing or Designee will audit all new aspiration risk orders will be reviewed for accuracy to the C.N.A. assignments and Quick Care Reference tool in the EHR. Audits will be reviewed monthly in QA until 100% is achieved for three (3) consecutive months.	

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F 684	Continued From page 11 R37 required aspiration precautions and was to be supervised with all meals. E13 commented that she would "Go right down." 4/16/21 12:45 PM - During an interview, E11 (RD) confirmed R37's physician's order for aspiration precautions. 4/16/21 3:05 PM - During an interview, E2 (DON) confirmed R37's physician's order included aspiration precautions and to be supervised by a staff member at all times when eating or drinking. E2 also confirmed that the CNA's could identify R37's dining needs/status in the computerized CNA care documentation and in the quick care reference sheets. 4/21/21 3:00 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON), and E6 (MD) during the exit conference.	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §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, record review and interview it was determined that the facility failed to ensure that care planned fall prevention strategies were in place for one (R20) out four residents investigated for accidents. Finding	F 689	A.) Center cannot retroactively place Dycem on chair prior to inspection. Upon discovery, Dycem was placed on top of the cushion.	5/31/21

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F 689	Continued From page 12 include: The facility's Fall Management policy, dated October 2020, stated, "Purpose - Facility will evaluate fall risks and identify resident specific interventions to discourage the resident from falling and minimize complications from falling ...Staff will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls ...". The following was reviewed in R20's clinical record: 1/28/16 - R20 was admitted to the facility with multiple diagnoses including dementia. 11/13/20 11:50 AM - A facility incident report revealed that R20 was found on the floor after an unwitnessed fall in the Sussex Satellite Unit's common area, sent to the emergency room via emergency medical services and found to have a fractured left wrist. The investigation did not include if Dycems were in her wheelchair above and below the wheelchair cushion. 11/23/20 (last revised) - R20's care plan for falls included an intervention (Initiated 9/25/18) to have Dycems in her wheelchair above and below the wheelchair cushion. April 2021 - The facility CNA's documented every shift that R20 had Dycems "to wheelchair above and below w/c [wheelchair] cushion." 4/16/21 9:00 AM - During an observation in the Sussex Satellite Unit's common area, R20 was in her wheelchair at a table while E4 (RN, UM) sat	F 689	B.) All Residents who are designated as a high fall risk with dementia who use Dycem above and below wheelchair cushions are at risk. A whole house audit was conducted and all Dycem was in place. C.) RCA with E4 confirmed that though Resident did have Dycem in place during AM care, Resident can remove certain safety devices and treatments. 1.) All residents with high fall risk and dementia who can remove safety devices will have Dycem placement added to the existing frequent shift checks. 2.) Care plans for residents who are capable of removing safety devices requiring monitoring will be added. Staff Developer will develop in-service and RNAC will review all care plans for updates. D.) Director of Nursing and / or Designee will 1.) conduct ten (10) inspections of high fall risk residents with dementia that require Dycem above and below wheelchair cushions and who can remove safety equipment, verify placement, weekly. 2.) Will audit that inspected Residents had frequent checks for Dycem positioning and in notated on task list. Audits will be reviewed monthly in QA until 100% is achieved for three (3) consecutive months.	

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F 689	Continued From page 13 next to her supervising R20 eating breakfast. 4/16/21 9:05 AM - During an interview with E4 (RN, UM), R20's "Resident Care Need Quick Reference" was reviewed. When asked if R20 had Dycems to her wheelchair seat above and below the cushion, E4 said "Yes. I know because I put them there." 4/16/21 9:10 AM - During an observation E4 (RN, UM) and E5 (CNA) assisted R20 to a standing position to confirm placement of the Dycems. Both E4 (RN, UM) and E5 (CNA) confirmed there was only a Dycem under the wheelchair cushion and not one on top of it. 4/21/21 3:00 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON), and E6 (MD) during the exit conference.	F 689		
F 756 SS=D	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	F 756		5/31/21

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F 756	Continued From page 14 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 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 ensure that the physician documented in the resident's medical record the rationale for rejecting the irregularity identified by the pharmacist for one (R49) out of six sampled residents for medication review. Findings include: 7/1/19 (last revised) - The facility policy entitled Pharmacy Service: Medication Regimen Review (MMR) included that: " ...Recommendations are acted upon and documented by the facility staff and or the prescriber within 21 days. Physician accepts and acts upon suggestion or rejects and provides an explanation for disagreeing. If there is potential for serious harm and the attending	F 756	A.) Center cannot retroactively make physician document reason to go against pharmacist recommendations. Order has since been discontinued. Attending physician in order no longer practices at the center. B.) All Residents who have a pharmacy recommendation to the attending physician that is not followed and without a physician explanation are at risk. Pharmacy contacted to assist in whole house audit and confirmed that this occurrence was singular. Pharmacy confirmed that new attending physicians and staff have been 100% complaint with	

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F 756	Continued From page 15 physician does not concur, or the attending physician refuses to document an explanation for disagreeing, the director of nursing will contact the consultant pharmacist and the medical director on or before midnight of the next day ...". The following was reviewed in R49's clinical record: 11/6/20 - The Consultant Pharmacist Report of the monthly MRR documented for R49 "Can [name of a nasal spray] ordered daily long term be made PRN [as needed] or discontinued to eliminate risk of nasal passage ulcerations and nasal septal perforations ...". The form contained boxes to check "agree", "disagree" or "other" which were all blank. E28 (attending physician) wrote "cont [continue] as ordered", but no rationale was documented. 04/20/21 1:32 PM - During an interview, E2 (DON) confirmed the facility could not provide any documentation by E28 (attending physician) why the pharmacist's recommendation was not followed. 4/21/21 3:00 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON), and E6 (MD) during the exit conference.	F 756	pharmacy recommendations and / or documented changes against recommendations. C.) RCA confirmed that previous attending physician was not available for interview. Center noted that Physician practice was aware of their change of their role of attending services at the time of the recommendation. Pharmacy has agreed to send a report of non-compliance with pharmacy recommendation into the DON and / or Medical Director every 30 days to provide follow-up. D.) Director of Nursing and / or Designee will educate all new NP's and attending physician on process and confirm their understanding of compliance on an education. Director of Nursing and / or Designee will audit that reports are arriving and addressed timely. Audits will be reviewed monthly in QA until 100% is achieved for three (3) consecutive months.	
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.	F 812		5/31/21

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F 812	Continued From page 16 (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 it was determined that the facility failed to monitor food temperatures in accordance with professional standards for food safety for cooking/reheating food items, maintaining consistent temperature logs, ensuring appropriate strength of sanitizing solution, and storing cookware in a manner that prevents contamination. Findings include: 1. 4/13/21- 9:35 AM - During a tour of the kitchen, the sanitizing solution in a red sanitizer bucket was tested for chemical concentration by E26 (Cook). The chemical concentration level was too low and did not register at a sanitizing level on the test strip. 4/13/21 - 9:40 AM - The ineffective level of sanitizer in the bucket was confirmed by E17 (Food Service Director) 2. 4/13/21 - 9:47 AM - During a review of the food temperature logs, the surveyor observed ninety-four (94) meals out of three hundred-six meals (306) reviewed for temperatures had no	F 812	A.) Center cannot retroactively change initial sanitizer effective level. Sanitizer was changed to correct level and all items washed were rewashed with new level. Center cannot retroactively reinsert missing temperatures. All Temperatures were current. Center cannot retroactively store pans face down. Upon discovery, all pans were placed upside down. B.) All Residents can be affected by these practices. Immediate in-service was provided on pots and pans storage, temperature check documentation, and sanitizer levels. C.) RCA determined that the temperature documentation was not verified between AM and PM cooks. Signage on storage of pots and pans had fallen off the storage area wall, and double check of sanitizer levels had not occurred using a daily log (vendor contacted for sample or better product or dispenser). 1.) Signage	

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F 812	Continued From page 17 temperatures recorded. Temperatures of cooked foods and cold ready to eat foods were not being consistently recorded prior to being served. Fish, meat, and poultry must be heated to an appropriate specific temperature depending on the type of food and the method used to prepare it. Vegetables must be heated to one hundred thirty-five (135) degrees Fahrenheit (F), and cold ready to eat foods must be held below forty-one (41) degrees (F) to maintain food safety. 4/13/21- 10:10 AM - E17 (Food Service Director) confirmed the missing food temperatures. 3. 4/13/21 - 10:47 AM - During a tour of the kitchen, the surveyor observed two large pans and a stack of smaller pans being stored upright exposing the food contact surface to dust and other contamination. 4/14/21 - 12:42 PM - E17 (Food Service Director) confirmed the incorrectly stored cookware. 4/21/21 3:00 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON), and E6 (MD) during the exit conference.	F 812	replaced for proper pot and pan storage. 2.) Audit tool created to monitor end of day temperature log verification and sanitizer level daily. D.) Food Service Director, Dietitian, and / or Designee will conduct the focused audits daily. Audits will be reviewed monthly in QA until 100% is achieved for three (3) consecutive months.	
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control 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	F 880		5/31/21

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F 880	Continued From page 18 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 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	F 880		

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F 880	Continued From page 19 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 observations, record reviews, interviews and review of facility policies and other documentation as indicated, it was determined that the facility failed to maintain an infection prevention and control program that included ongoing review of surveillance data, analysis of surveillance data, and documentation of follow up activity in response to collected surveillance data. The facility failed to ensure that monthly tracking and surveillance data of non-COVID-19 infections were reviewed, analyzed and acted upon if indicated, for the months of May, June, July, August, September, and October of 2020, as well as January and February of 2021. Additionally, observations of facility staff revealed deficient practice in the area of disinfection of reusable vital sign equipment between resident use for four randomly observed residents (R17, R22, R57, and R81). Findings include: 1. The facility's Infection Surveillance policy,	F 880	A.) Center cannot retroactively create non-Covid-19 Infection reviews for May 2020 through October 2020. Center cannot retroactively provide sanitization between use of vital equipment between Residents. Pharmacy and lab reports for the missing months were found and an ad hoc QA meeting with DON, IPC, Medical Director, Pharmacy Representative and Lab representative will be conducted before the end of May 2021. Immediate education to nursing staff provided on proper disinfection of the shared equipment. B.) All residents can be affected by this practice. C.) RCA confirmed that policy from October 2020 did not address reviews during Covid-19 emergency or other EOP	

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	085029	A. BUILDING _____ B. WING _____	C 04/21/2021

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F 880	Continued From page 20 dated October 2020, stated, "Purpose - The Infection Preventionist will conduct ongoing surveillance for Healthcare-Associated infections and other significant infections that have potential to affect resident outcome and that may require transmission-based precautions and other preventative interventions ...The Infection Preventionist or designated infection control personnel is responsible for gathering and interpreting surveillance data. The Infection Control Committee and/or QAPI [Quality Assurance Process Improvement] Committee may be involved in interpretation of the data ...". 4/20/21 9:40 AM - E7 (RN, ICP) provided the facility's 2020 Infection Control Surveillance notebook and packets for January, February, and March 2021 data collected. E7 stated the facility has not completed analysis of any surveillance data for 2021 yet. 4/20/21 4:26 PM - During an interview, when asked about missing data and analysis in the 2020 Infection Control Surveillance notebook for six months (May through October), E2 (DON) stated that after she and E7 (RN, ICP) began work at the facility in the fall of 2020, they have tried to keep up with the data surveillance and confirmed the 2021 data has not been analyzed yet. E2 stated that she will try to locate any missing 2020 data from E3 (ADON) and E23 (RN, previous Staff Educator). 4/21/21 8:37 AM - During an interview, E2 (DON) stated the facility could not provide any analysis of non-COVID-19 infections for May - October 2020, but provided some notes of data collected by staff during this time. E2 (DON) stated the facility was focused on COVID-19, but she	F 880	protocols. Though present IC staff was not here during the May to October 2020, a retroactive review was not performed timely. Medical Director agreed that data from pharmacy and lab would satisfy a late review. RCA confirmed that the nursing Medication and treatment carts were being exchanged during the survey period and the newer wider cart with more storage had not had the equipment basket and sanitization station installed. Inservice on new cart use, storage and sanitization supplies occurred and carts completed installation. E27 explained E27 panicked when interviewed by surveyor on IC process and response. E27 had a separate in-service on equipment sanitization and responding with surveyors and what is expected during survey. D.) Director of Nursing and / or designee will audit the next QA meeting to assure missing data is reviewed and annotated into QA process. Director of Nursing and / or Designee will observe ten (10) uses of multi-resident use equipment for sanitization practices applied between use and ten (10) observations that the new carts contain enough storage space and sanitization to effect best practice. Audits will be reviewed monthly in QA until 100% is achieved for three (3) consecutive months.	

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F 880	Continued From page 21 thought regional consultants from corporate were putting data in the EMR on antibiotic use. Review of print outs from the EMR lacked sensitivity results correlated to antibiotic use or any actions taken by the facility. 4/21/21 2:00 PM - During an interview, E1 (NHA) stated the facility could not provide documentation that non-COVID-19 infection surveillance or analysis was discussed in the QAPI meetings. 2. The facility's "Cleaning and Disinfection of Resident Care Items/Medical Equipment" policy, dated 10/2020, stated, "Purpose - Resident care equipment, including reusable items and durable medical equipment will be cleaned and disinfected to prevent the spread of infection...Multi-resident reusable items that do not come in contact with mucous membranes (e.g. blood pressure cuffs, stethoscopes, sit-to-stand lifts, etc.) can be disinfected where they are being used between residents...". 4/19/21 from 8:45 AM to 9:30 AM - The following was observed during a medication pass observation with E27 (RN): 8:45 AM - E27 was observed leaving R57's room after taking her blood pressure with the rolling vital sign machine. E27 placed the vital sign machine next to the medication cart without disinfecting it. 8:55 AM - E27 was observed entering R81's room, removing a pulse oximeter from her scrub uniform pocket and placing it on R81's finger. After registering the oxygen saturation and heart rate, E27 placed the pulse oximeter into her scrub	F 880		

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F 880	Continued From page 22 pocket without disinfecting it. 9:10 AM - E27 was observed entering R22's room with the unclean rolling vital sign machine and took R22's blood pressure twice. E27 removed a pulse oximeter from her scrub uniform pocket and placed it on R22's finger. After registering the oxygen saturation and heart rate, E27 placed the pulse oximeter into her scrub pocket without disinfecting it. E27 left the room and placed the vital sign machine next to the medication cart without disinfecting it. 9:30 AM - E27 was observed entering R17's room, removing a pulse oximeter from her scrub uniform pocket and placing it on R17's finger. After registering the oxygen saturation and heart rate, E27 placed the pulse oximeter into her scrub pocket without disinfecting it. 4/19/21 12:25 PM - During an interview, E3 (ADON) confirmed that the facility's expectation is for staff to disinfect reusable resident equipment, such as blood pressure cuffs and pulse oximeters, with wipes between resident uses. E3 stated that both nursing stations and medication carts are stocked with disinfectant wipes for this purpose. 4/19/21 2:25 PM - During an interview, E27 (RN) confirmed that she did not disinfect the blood pressure cuff or pulse oximeter she used this morning on multiple residents between uses. She was shown the policy that E3 (ADON) provided and said she was not aware of the need to disinfect the equipment between uses, but said she will begin doing this now. During medication pass observation,	F 880		

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F 880	Continued From page 23 contaminated medical equipment was not cleaned after use. 4/21/21 3:00 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON), and E6 (MD) during the exit conference.	F 880		