STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085001	A. BUILDING _____ B. WING _____	C 01/21/2020

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KENTMERE REHABILITATION AND HEALTHCARE CENTER	1900 LOVERING AVENUE WILMINGTON, DE 19806

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E 000	Initial Comments An unannounced annual and complaint survey was conducted at this facility from January 8, 2020 through January 21, 2020. The facility census the first day of the survey was 102. 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, complaint and emergency preparedness survey was conducted at this facility from January 8, 2020 through January 21, 2020. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other documentation as indicated. The facility census the first day of the survey was 102. The survey sample size was 43 residents. Abbreviations/definitions used in this report are as follows: 1:1 Supervision - one staff person assigned direct supervision of a resident; 1:2 Supervision - one staff person assigned to direct supervision of two residents; ADON - Assistant Director of Nursing; Anemia - low number of red blood cells in the bloodstream; Biologicals - medicinal preparations made from living organisms and their products, including	F 000		

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

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	F 000		

serums, vaccines, and antigens;
Broda - a brand name;
Broda chair - a chair that provides tilt-in-space positioning and mobility;
CNA - Certified Nurse's Aide;
Compression fracture - typically caused by a loss of bone mass (osteoporosis) that occurs as part of aging. A fall, cough, or lifting of a heavy object may cause a fracture of the back bones;
Dart/Paratransit - A division under the Delaware Department of Transportation public transit program responsible for transporting individuals that qualify under the Americans with Disabilities Act. Furthermore, the service must be vested and each rider has their own unique identification;
Degenerative Joint Disease - type of arthritis that occurs when flexible tissue at the ends of the bones wear down;
Dementia - group of thinking and social symptoms that interferes with daily functioning;
DON - Director of Nursing;
E - Employee;
eMAR - Electronic Medication Administration Record;
eTAR - electronic Treatment Administration Record;
F - Family;
Fracture - broken bone;
L1- Lower back or the lumbar spine at level 1;
MD - Medical Doctor;
MDS assessment - Minimum Data Set/standardized assessment tool used in Long Term Care;
mg - milligram;
ml - milliliter;
NHA - Nursing Home Administrator;
Neuropathy - weakness, numbness, and pain from nerve damage, usually in the hands and feet;

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F 000	Continued From page 2 Osteoarthritis - type of arthritis that occurs when flexible tissue at the ends of the bones wear down; Osteoporosis - condition in which bones become weak and brittle; OT - Occupational Therapy; OTR/L - OT Registered/Licensed; PRN - as needed; R - Resident; RD - Registered Dietician; T10 - thoracic spine at level 10; Thoracic spine - the spinal column that runs from the base of the neck down to the abdomen; Transient Ischemic Attack - A brief stroke-like attack that, despite resolving within minutes to hours, still requires immediate medical attention to distinguish from an actual stroke; Transverse process fracture - a type of fracture that has a horizontal fracture line; UM - Unit Manager.	F 000		
F 585 SS=F	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in	F 585		

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F 585	Continued From page 3 accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing	F 585		

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F 585	Continued From page 4 written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on interviews and review of the facility's	F 585		

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F 585	Continued From page 5 Grievance Policy and Procedure and Grievance Logs, it was determined that for three (R14, R43 and R153) out of three sampled residents investigated for personal property, the facility failed to establish a system of filing grievance reports to include lost and missing personal items and belongings. Findings include: The facility's policy on Grievances, dated April 2017, documented, "All grievances reported by a resident, responsible party, resident representative or family member will be promptly investigated and resolved. Follow - up will be reported to the resident and/or reporting party...Procedure #1. The facility will make information on how to file a grievance or complaint available to residents by posting in prominent locations throughout the facility of the right to file grievances or by providing such notice directly to residents in writing...#3. The Grievance Official shall be responsible for a. Overseeing the grievance process; b. Receiving and tracking grievances through to their conclusion...g. The Grievance Official for each Facility is the Social Services Director...#4 Process...C. All grievances or concerns that are reported by a resident or other party to an individual other than the Grievance Officer shall be immediately reported to the receiving individual's supervisor and the Grievance Officer." 1. 1/8/20 at 10:09 AM - In an interview during the initial screening, F1 (R153's wife) revealed to the surveyor that R153 was missing 8 pairs of non - skid socks and a pair of dark colored pants that R153 brought with him on admission on 12/26/19. F2 (R153's private caregiver) who was also at the bedside stated that they already verbally reported the missing socks and pants to E5 (UM/RN), but	F 585		

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F 585	Continued From page 6 have not heard any feedback yet. 1/10/20 at 1:52 PM - Review of the facility's Grievance log did not show evidence that R153's missing non - skid socks and pair of pants were documented. 2. 1/9/20 at 9:14 AM - During the initial screen, F3 (R43's husband) told the surveyor that approximately 2 weeks ago, F3 brought a loose (old black and white) picture of R43 when she was 18 years old and left it on the bedside table. F3 said the picture disappeared and he reported it to E5 (LPN). F3 further stated that the picture was "sentimental" and he thought the resident would enjoy seeing the picture. 1/10/20 at 2:00 PM - Review of the facility's Grievance log did not show evidence that R43's missing black and white picture was documented. 1/13/20 at 9:39 AM - In an interview, E3 (Social Worker) confirmed that the missing items of R153 and R43 were not reported to her and she did not know about them. E3 further stated that lost items were usually not filed on the grievance form and added, "I don't know if reporting lost items is a component of filing a grievance. I'm not sure if staff are educated on filing a grievance and if missing items are to be filed in the grievance. I'm not sure if we tell families that they have to file a grievance form every time something is missing." 1/13/20 at 3:52 PM - E2 (DON) confirmed to the surveyor that the facility did not have a system in place for reporting, documenting and following up on residents' missing/lost items and belongings.	F 585		

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F 585	Continued From page 7 1/15/20 at 5:15 PM - Findings were discussed with E1 (NHA) and E2. 1/21/20 at approximately 1:30 PM - Findings were reviewed during the exit conference with E1, E2, E23 (ADON), and E24 (Staff Educator). 3. R14 reported to a surveyor on 1/8/2020 at approximately 3:55 PM that she had a paisley sleeveless blouse missing for over 5 months. R14 was not able to find any documentation regarding the missing personal item. It was further revealed during an interview between another surveyor and E2 (DON) on 1/13/20 at 3:52 PM that the facility did not have a system in place for reporting, documenting and following up on residents' missing/lost items and belongings. 1/16/20 at 5:15 PM - Findings were discussed with E1 (NHA) and E2. 1/21/20 at approximately 1:30 PM - Findings were reviewed during the exit conference with E1, E2, E23 (ADON) and E24 (Staff Educator).	F 585		
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	F 656		

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F 656	Continued From page 8 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 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 two (R47 and R68) out of 23 sampled residents for investigations, the facility failed to develop comprehensive care plans for	F 656		

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F 656	Continued From page 9 identified resident care areas. Findings include: 1. Review of R47's medical records revealed the following: 4/22/18 - R47 was admitted to the facility. 8/7/19 - The significant change MDS assessment documented that R47 was severely impaired for daily decision making. 10/29/19 - A physician's order was obtained for Remeron (a medication to treat depression) daily for a diagnosis of major depressive disorder. 10/29/19 through 1/16/2020 - Review of the eMAR documented that R47 was administered Remeron on a daily basis as ordered. There was a lack of evidence of a care plan for depressed mood, including R47's behavioral expressions or indications of depressed mood, both non-pharmacological and pharmacological interventions, plans to monitor, and establishment of a measurable goal. 1/21/20 11:30 AM - An interview with E2 (DON) confirmed that the facility failed to develop a care plan for R47's depressed mood. 2. Review of R68's medical records revealed the following: 8/10/17 - R68 was admitted to the facility. 10/7/19 - A physician's order was obtained for Zoloft (a medication to treat depression) on a daily basis to treat R68's depressed mood.	F 656		

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F 656	Continued From page 10 10/7/19 through 1/16/20- Review of the eMAR documented that R68 was administered Zoloft on a daily basis as ordered. 11/15/19 - The quarterly MDS assessment stated R68 was severely impaired for decision making, had both short and long term memory problems, and did not have any problems with mood. There was a lack of evidence of a care plan for depressed mood, including R68's behavioral expressions or indications of depressed mood, both non-pharmacological and pharmacological interventions, plans to monitor, and establishment of a measurable goal. 1/16/20 11:33 AM - An interview with E23 (ADON) confirmed the lack of a care plan for depressed mood. 1/21/20 11:30 AM - An interview with E2 (DON) confirmed that the facility failed to develop a care plan for R68's depressed mood. 1/21/20 at approximately 1:30 PM - Findings were reviewed with E1 (NHA), E2 (DON), E23 (ADON), and E24 (Staff Educator) during the exit conference.	F 656		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by:	F 658		

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F 658	Continued From page 11 Based on observations and interviews, it was determined that the facility failed to meet professional standards of quality for one (R42) out of 43 residents sampled for care reviews and for one (R71) out of four residents sampled in the area of medication administration. For R42, the facility failed to ensure that treatments that were not completed according to physician's orders were not signed off as completed. The facility failed to ensure that when R71's medication supply of Tylenol ran out, it was not taken from another resident's medication supply. Findings include: 1. Review of R42's clinical record revealed the following: 7/30/19 - R42 was admitted to the facility with diagnoses that included high blood pressure and chronic kidney disease. 12/27/19 - A physician's order stated R42 was to have ACE wraps (an elastic bandage) applied to the lower legs, on in the AM, off in the PM. The following observations were completed of R42: 1/13/2020 at 8:38 AM - R42 was observed seated in a wheelchair (W/C) in the dining room not wearing her ACE wraps on her lower extremities. 1/13/2020 at 10:23 AM - R42 was observed seated in a W/C having her fingernails painted by an activity aide, not wearing ACE wraps on her lower extremities. 1/13/2020 at 2:15 PM - R42 was observed in her room with family present, not wearing ACE wraps to her lower extremities. 1/14/2020 at 8:55 AM - R42 was observed in the	F 658		

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F 658	Continued From page 12 dining room during breakfast not wearing ACE wraps on her lower extremities; 1/14/2020 at 10:30 AM - R42 was observed at a religious activity in the main dining room not wearing ACE wraps on her lower extremities; 1/14/2020 3:45 PM - R42 was observed in her room watching TV with family present, not wearing ACE wraps on her lower extremities. During an interview at this time, F4 (family member) stated that the ACE wraps are applied occasionally, but not every day. 1/15/2020 12:25 AM - R42 was observed in the dining room waiting for lunch not wearing ACE wraps on her lower extremities. Review of R42's eTAR for 1/13/2020, 1/14/2020 and 1/15/2020 revealed that at 9:00 AM the 7 AM to 3 PM nurse, E25 (LPN), signed off that ACE wraps were applied on all three (3) days. The eTAR also revealed that on 1/13/2020 and 1/14/2020 at 9:00 PM, E26 (LPN), the 3 PM to 11 PM nurse, signed off that the ACE wraps were removed. 1/15/2020 at approximately 1:50 PM - During an interview, the eTAR was reviewed with E25 and that he had signed off that ACE wraps were applied on 1/13/2020 through 1/15/2020. E25 looked puzzled and stated that the resident did not wear ACE wraps on her legs. E25 stated that at one time, R42 had an order to have an ACE wrap applied to her hand. The facility failed to ensure that professional standards of quality were followed when the facility failed to ensure that treatments that were not done according to physician's orders were not signed off as having been completed.	F 658		

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F 658	Continued From page 13 1/15/2020 at approximately 4:20 PM - Findings were reviewed with E1 (NHA) and E2 (DON). 1/21/2020 at approximately 1:30 PM - Findings were reviewed during the exit conference with E1, E2, E23 (ADON), and E24 (Staff Educator). 2. The facility's policy titled Medications Not Available, dated May 2016, documented, "Procedure #1. When a medication is not available from the pharmacy, the nurse should then attempt to secure the medication from the Starter Box or the Emergency Box. Procedure #2. If the medication is still not available from either of these sources, call the physician to determine if an alternate treatment plan is required. Document interventions in a progress note, via electronic record." 1/10/20 at 7:49 AM - E4 (RN) was observed preparing oral medications for R71 during medication pass. E4 was observed dispensing 2 tablets of Tylenol 500 mg from another resident's (R20's) medication card. E4 stated to the surveyor that R71's Tylenol had not yet arrived from the pharmacy, so she would "borrow" from the other resident because "they have the same prescribed Tylenol dose and strength." When the surveyor asked E4 if the facility had Tylenol 500 mg in house stock, E4 replied, "No, only Tylenol 325 mg." Findings were confirmed by E4. 1/13/20 at 8:40 AM - Findings were discussed with E2 (DON). 1/21/20 at approximately 1:30 PM - Findings were reviewed with E1 (NHA), E2 (DON), E23 (ADON), and E24 (Staff Educator) during the exit conference.	F 658		

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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 interviews, record review, and review of other facility documentation, it was determined that the facility failed to ensure that R52 received care and services that are resident centered, in accordance with the resident's preferences, goals for care and professional standards of practice that will meet R52's physical, mental, and psychosocial needs by not following the facility policy regarding an unscheduled LOA on 9/3/19. Findings include: Review of R52's clinical record revealed the following: R52 was admitted to the facility on 2/7/18. According to the facility Nursing Policy, dated February 2016, regarding Leave of Absence, the policy stated, "To establish guidelines for therapeutic leave of absence and to ensure accountability for resident's location. All residents leaving the facility with responsible party or by themselves are required to record their name in the Sign Out Book/Leave of Absence Register. All leaves of absence will be approved by the physician and documented in the electronic	F 684	Past noncompliance: no plan of correction required.	

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F 684	Continued From page 15 records by the nursing staff... 1. All leaves for residents will be recorded in the Sign-out Book/Leave of Absence Register located at each nurse's station. The register includes the name of the resident, date, and the time he/she left the facility; and the date and time the resident returned to the facility. Day passes and overnight leaves will be recorded on the register ... 6. Staff observing a resident leaving the premises and having doubts about the resident being properly signed out, should notify the supervisor at once." R52's most recent MDS at the time of the incident was a PPS (Prospective Payment System) 5-day scheduled assessment on 8/28/19. R52 had a BIMS score of 5 indicating that R52's cognitive status was severely impaired with never/rarely making decisions. The facility reported the following incident to the Division of Health Care Quality on 9/3/19 at 9:00 AM: "At approximately 0900 on 9/3/19, a driver from Dart (Paratransit) transportation arrived at facility stating that resident (R52) had an appointment and they were there to transport him. Facility was unaware of appointment. Resident left facility via Dart and facility received a phone call from resident's daughter stating that resident was in Georgetown, DE at Del Tech and stated that she was unaware he had an appointment. Daughter called Dart and informed them there was no appointment and resident was immediately placed on a Paratransit vehicle to return to facility. Facility van met resident in Smyrna and transported him back to Kentmere. Paratransit stated that they had a voicemail from the daughters stating that he had an appointment.	F 684		

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F 684	Continued From page 16 Daughters stated they did not make any such appointment. Resident returned to facility at 3pm and appeared in no distress." An interview with E2 (DON) on 1/14/2020 at approximately 11:07 AM revealed that E30 (Office Manager) and E25 (LPN) did not see an appointment, but proceeded to release R52 to Paratransit. E2 stated that fortunately, R52 did not miss any medication, was not in distress, nor developed any health issues as a result of the incident. E2 confirmed the LOA policy in place when the incident occurred was identified as a problem in the root cause analysis. Although Paratransit is a government funded transportation service with a formalized reservation system, the facility will now require all residents and responsible parties to provide written documentation for LOA. The facility updated the new policy to designate explicit roles and requirements for LOA to prevent further incidents from happening. The facility educated all staff affected by the policy and provided documentation. Lastly, the facility conducted audits on the new LOA sign out from 10/1/19 until 12/31/19. Due to the facility meeting the criteria of a corrected plan of correction prior to identification during the annual survey, this deficiency will be cited as past-noncompliance. 1/21/20 at approximately 1:30 PM - Findings were reviewed with E1 (NHA), E2 (DON), E23 (ADON), and E24 (Staff Educator) during the exit conference.	F 684		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents.	F 689		

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F 689	Continued From page 17 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 record review, interview, review of hospital records and other facility documents as indicated, it was determined that the facility failed to ensure that the resident received adequate supervision to prevent accidents for one (R47) out of three sampled residents for fall investigations. For R47, the facility failed to ensure adequate supervision by failing to ensure close monitoring/supervision of R47, a resident with dementia, poor safety awareness, a history of multiple falls, and attempting to stand up without assistance. This deficient practice resulted in harm to R47 when she was left unattended, not monitored and not supervised and fell in the common area of the unit. R47 required emergent transfer to the hospital where it was confirmed that she sustained a new L1 compression fracture and a right T10 transverse process fracture. Findings include: The facility's policy titled Fall Prevention & Management Guidelines, dated June 2016, stated: "...8. The Interdisciplinary Team will review the fall and will complete the following documentation: - Obtain physician's orders as needed. - Update Care Plans as needed. - Update CNA flow records as needed. - The DON/designee will complete the DON Post	F 689		

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F 689	Continued From page 18 Fall Follow-up. 9. The Unit Manager is responsible for initiating recommendations and communicating them to the staff. 10. Interventions will be periodically re-evaluated to determine the continued need as well as effectiveness. Changes will be made as Interdisciplinary Team determines them appropriate." The facility's In-Service Attendance Sheet, dated 1/25/19, for the topic title of "1:1 or 1:2 Supervision, Broda Chair Requirements," presented by E23 (ADON), stated, "...1:1 or 1:2 Supervision, staff member within arm reach at all times, Do not leave resident alone, notify nurse or another CNA, follow provided list if time is not adequate notify nurse... Broda Chair, used for fall risk, do not lock the chair...". 1. Review of R47's medical record revealed the following: 4/22/18 - R47 was admitted to the facility with diagnoses that included pelvic fracture secondary to a fall, dementia, high blood pressure, and anemia. 4/22/18 (Original date) - A care plan was initiated for falls due to a history of falls and an unsteady gait. The care plan interventions included to analyze any resident falls that may occur to determine whether a pattern or trend can be addressed; appropriate footwear non-skid shoes or slippers when out of bed; fall mats on sides of bed when resident in bed and remove when resident is out of bed; 1:2 supervision; encourage resident to participate in the Restorative Nursing	F 689		

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F 689	Continued From page 19 Program's walking program when restless; and Broda chair when out of bed. 4/11/19 - The attending physician's history and physical documented diagnoses including high blood pressure, osteoarthritis, osteoporosis, transient ischemic attack, and degenerative joint disease. 7/31/19 - A physician's order was obtained from E7 (MD) for 1:2 supervision when out of bed. 8/7/19 - A significant change MDS assessment stated R47's daily decision making skills were severely impaired, she required limited assistance of one staff for transfers and toilet use, and did not walk in her room or the corridor. The MDS stated R5's balance while moving from a seated to standing position, walking, and transfers between bed and chair or wheelchair were not steady, and was able to only with staff assistance. R47 experienced one fall with a non-major injury. 10/17/19 1:00 PM - The facility's Incident/Accident Report stated that R47 had an unwitnessed fall, staff heard a thump and turned around to see R47 sitting on the floor, in front of the Broda chair with no injury. Witness statements from all nursing staff assigned to the 7:00 AM to 3:00 PM shift [(E9 (RN), E11 (CNA), E12 (CNA), and E13 (CNA)] documented that nursing staff did not observe the fall. All four employees documented that the contributing factor was R47 trying to get up to walk or perform a transfer. The assigned CNA, E11's statement documented that she was away from the area when R47 fell.	F 689		

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F 689	Continued From page 20 10/18/19 2:41 PM - The Occupational Therapy Treatment Encounter Note, by E17 (OTR/L) documented that R47 was referred to OT following a fall. The note documented, "...pt. (patient) does not remember the fall, pt. has behavior of attempting to stand, pt. is assist of 1. pt. now on 1:1. Staff educated on activities appropriate for pt.'s cognitive level..." 10/18/19 6:30 PM - The facility's Incident/Accident Report stated that R47 had an unwitnessed fall in the common area of the unit. R47 was found laying on her side and upon assessment had no apparent injury and was placed back into the Broda chair. Approximately two hours after the fall, R47 complained of back pain and an order was obtained to transfer R47 to the hospital. Witness statements from all nursing staff assigned to the 3:00 PM to 11:00 PM shift [(E14 (LPN), E15 (CNA), and E16 (CNA)] documented that nursing staff did not observe the fall. All three employees documented the contributing factor was that R47 was left unsupervised. In addition, to prevent further unwitnessed falls, 1:1 supervision was to be implemented. 10/18/19 - R5 was treated in the emergency room. Review of the hospital record revealed that R47 sustained a new L1 compression fracture. 10/18/19 10:00 PM - R47 returned to the facility with an order for Tramadol as needed for severe pain. 1/14/2020 10:41 AM - An interview with E10 (RN, UM) was conducted. E10 confirmed that after the 10/17/19 fall, no new interventions and/or revisions of interventions to prevent further falls	F 689		

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and injury were completed. E10 verbalized that a post fall assessment by the therapy department was completed following the fall on 10/17/19, however, there were no changes in interventions. E10 confirmed that R47 had an order for 1:2 supervision when out of bed and stated this would have been communicated to the assigned CNA during the shift change.

1/14/2020 3:30 PM - An interview with E14 (LPN) revealed that, at approximately 6:30 PM, R47 was in the common area and E14 verbally instructed E15 (CNA) to "Keep an eye on her" due to R47's high risk for falls as E14 would be starting medication administration and would not be in the common area to supervise R47. E14 stated that she was not notified when E15 left the common area and left R47 unsupervised. E14 verbalized that the fall was unwitnessed, as E15 and E16 (CNA) were not in the common area and were placing other residents to bed. After the fall, R47 was placed back in the Broda chair in the common area and approximately 2 hours afterwards, R47 started grimacing, thus E14 (LPN) contacted E7 (MD) and an order was obtained to transfer R47 to the hospital.

1/15/2020 10:40 AM - An interview with E17 (OTR/L) revealed that she completed a post fall assessment following the 10/17/19 fall. R47's functional status remained unchanged and R47 continued to require assistance of one staff for transfers. E17 verbalized that the 1:1 supervision was a new intervention, as R47 was at high risk for additional falls following the 10/17/19 fall. E17 verbalized that she educated the nursing staff following the post fall evaluation on activities for R47.

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F 689	Continued From page 22 1/15/2020 1:45 PM - An interview with E2 (DON) revealed that R47 had a history of impulsiveness, including standing up without assistance and poor safety awareness, which resulted in multiple falls in the facility. E2 stated that on 7/31/19, an intervention of 1:2 supervision was ordered and implemented as an intervention for prevention of falls and injury. E2 verbalized for the 10/17/19 fall, E9 (RN) was changing the channel on the TV and had her back towards R47, heard a thump and observed R47 on the floor. The surveyor provided a copy of the OT Note, dated 10/18/19, which documented 1:1 supervision, however, E2 verbalized that she was not aware of this note until it was provided by the surveyor. E2 verbalized that there were no changes in interventions after the 10/17/19 fall. E2 confirmed the ordered 1:2 supervision was not implemented when R47 fell on 10/18/19 at 6:30 PM. In addition, E2 confirmed that 1:1 supervision was not in place when E47 fell on 10/18/19. 1/16/2020 10:57 AM - An interview with E7 (MD) revealed that R47 had osteoarthritis and osteoporosis and E7 could not rule out that the new L1 compression fracture was caused by the fall on 10/18/20 when R47 had a new onset of pain. 1/21/2020 11:30 AM - Findings were reviewed with E1 (NHA) and E2 (DON). E1 verbalized that E7 (MD) stated that the L1 compression fracture could have happened without the fall. The surveyor replied that during an interview with E7, E7 verbalized that she could not rule out that the fall resulted in the fracture. E1 and E2 verbalized that they were not able to provide evidence of 1:2 supervision for R47, thus, following the 10/18/19 fall, the order was discontinued.	F 689		

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F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, clinical record reviews and review of facility documents as indicated, it was determined that for two (R65 and R94) out of three (3) residents sampled in the area of nutrition, it was determined that the facility failed to recognize, evaluate, and address a weight change and/or complete re-weights in order to maintain acceptable parameters of nutritional status. For R65, the facility failed to initially identify a weight loss, and failed to complete re-weights per physician's orders and facility policy and procedure. For R94, the facility failed to complete a re-weight according to facility policy and procedure when a weight loss	F 692		

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F 692	Continued From page 24 occurred. Findings include: The facility policy titled Weights and Weight Loss Protocol, effective date June 2016, stated the policy was to outline a standard process for admission weights and weight loss response. "...Procedure:...7. Monthly weights will be taken by the 5th of the month for all residents and recorded on the monthly weight forms...9. Re-weighs will be done on any resident who experiences: 3 pounds weight fluctuation and is less than or equal to 100 pounds; 5 pounds weight fluctuation and is greater than or equal to 100 pounds; 10 pounds weight fluctuation and is greater than or equal to 200 pounds. 10. Re-weighs will be done within 24 hours in the presence of a nurse. The re-weight will be documented in the re-weight column of the weight form and entered into the monitoring section of the EMR (Electronic Medical Record) by the 10th of the month by the Unit Nursing Manager or Designee. 11. Once the weight fluctuation has been confirmed the Dietician/designee will be notified. *NOTE: Significant weight change is defined as 5% change in 30 days or 10% in 180 days...". The facility's Monthly Weight/Vital Sign Worksheet stated, "*Note: Any resident with a significant weight change of 5 lbs (pounds) if > (greater than) 100 lbs or 3 lbs if < (less than) 100 lbs is to be reweighed within 24 hours with a nurse present. A dietary alert sheet is to be submitted for any resident with a confirmed significant weight change." 1. Review of R65's clinical record revealed the following:	F 692		

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4/7/11 - R65 was admitted to the facility. R65 had diagnoses that included a heart rhythm irregularity, high blood pressure, congestive heart failure (progressive heart disease that affects pumping action of the heart muscles) and a history of stroke with paralysis and aphasia (a communication disorder that results from damage or injury to language parts of the brain).

12/11/13 - A care plan was developed for "Resident is at risk for continued weight loss" and included the intervention to monitor weights monthly or as per MD order.

8/5/19 - R65's weight was recorded as 136.8 lbs. in the EMR.

8/29/19 - A quarterly MDS assessment stated that R65 had no short or long term memory problems, was independent for daily decision making (decisions consistent/reasonable) and was independent for eating with setup help only. R65's weight was documented as 137 lbs.

Review of the September 2019 Monthly Weight/Vital Sign Worksheet revealed documentation stating that R65's weight last month (August) was 136.8 lbs. and this month's (September) weight was 129.8 lbs. Despite this noted weight of 129.8 lbs. on the September 2019 Monthly Weight/Vital Sign Worksheet, the EMR documented on 9/5/19 that R65's weight was 136.8 lbs.

9/5/19 - R65's weight was recorded as 136.8 lbs. in the EMR.

10/4/19 - R65's weight was recorded as 131.4 lbs. in the EMR. This was a loss of 5.4 lbs. or

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 692	Continued From page 26 3.9% in one month based on the September 2019 recorded weight of 136. 8 lbs. Review of the EMR and the Monthly Weight/Vital Signs Worksheet lacked documented evidence that a re-weight was completed within 24 hours. Additionally, there was no documented evidence that E7 (MD) and E8 (RD) were notified of the weight loss. The November 2019 Monthly Weight/Vital Sign Worksheet documented that R65's weight last month (October) was 129 lbs. The EMR documented on 10/4/19 that R65's weight was 131.4 lbs. The November 2019 worksheet documented the current weight was 113 lbs. 11/6/19 2:58 PM - A nurse's progress note stated that R65 refused to be re-weighed after several attempts. 11/8/19 - R65's weight was recorded as 122.2 lbs. in the EMR. Documentation on the November 2019 Weight/Vital Sign Worksheet stated R65's weight was 113 lbs. Additionally, there was no documented evidence of a re-weight being completed, nor evidence of physician and RD notification. 11/11/19 8:54 AM - A nutrition note, completed by E8 (RD) stated that R65 had a 9 lb. weight loss over the last 30 days, the supplement would be increased to four times a day, and the MD was aware. 11/28/19 - An annual MDS assessment stated R65 had a short term memory problem, daily decision making skills were modified independence (had some difficulty in new situations only), and ate independently with setup help only. R65's weight was documented as 122	F 692		

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F 692	Continued From page 27 lbs. The December 2019 Monthly Weight/Vital Sign Worksheet documented R65's weight as 116 lbs. 12/5/19 - R65's weight was documented in the EMR as 120.4 lbs., obtained at 8:26 AM and 10:31 PM. 12/18/19 10:05 PM - A Nutrition progress note, completed by E8 (RD) stated, "Monthly weight shows continued weight loss despite increase in Medpass (nutritional supplement) to QID (four times a day) and she is eating 50-100% of most meals. Resident did have wheelchair change 12/2. Weekly weights x 4 ordered today. RD will follow up with weekly weights to assess weight trend and need for further dietary intervention." 12/19/19 7:26 AM - A physician's order was entered for R65 to have weekly weights completed on 12/19/19, 12/26/19, 1/2/2020, and 1/9/2020. 12/19/19, 12/26/19, and 1/2/2020 - Review of the TAR and progress notes lacked evidence that weekly weights were obtained for R65 or that she refused them. 12/23/19 - R65's weight was recorded in the EMR as 116.8 lbs. 1/5/2020 - R65's monthly weight was entered in the eTAR and EMR as 174.2 lbs. 1/6/2020 - A re-weight was entered in the EMR as 119.8 lbs. 1/9/2020 2:41 PM - A nurse's progress note	F 692		

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F 692	Continued From page 28 stated that R65 refused to have her weight taken. 1/9/2020 11:50 AM - R65 was observed at lunch where she ate a grilled cheese sandwich and drank 6 oz (ounces) of orange juice and 8 oz of coffee. 1/13/2020 8:35 AM - R65 was observed at breakfast eating oatmeal, and drinking 6 oz orange juice and 8 oz coffee. A dietary staff person offered R65 a danish to go with her coffee, but the resident refused. 1/14/2020 12:25 PM - R65 was observed at lunch where she was served a chicken drumstick, macaroni and cheese, spinach, 6 oz of water and 6 oz of cola. After eating the drumstick, half the macaroni and cheese, and drinking approximately 4 oz of the cola, R65 pushed herself away from the table and propelled herself out of the dining room. 1/15/2020 approximately 11:00 AM - During an interview, E29 (UM/LPN) stated that the RD reviews the weights and orders the re-weights. When asked if re-weights are done when there is a weight change before the RD reviews them, E29 stated that whoever enters the weights into the EMR, whether it's the UM or staff nurse, and sees there is a weight discrepancy should get a re-weight. 1/15/2020 approximately 1:45 PM - In an interview with E29 (UM/LPN) and E25 (LPN) they stated that they will obtain the monthly weight and if a weight loss is noted, a re-weight will be completed within 24 hours and entered into the "This Month Weight" column on the Monthly Weight/Vital Sign Worksheet. They stated that	F 692		

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F 692	Continued From page 29	F 692		

they do not enter the first weight that was obtained if a re-weight is completed. When asked how would the RD then know if a re-weight was completed if it was not entered on the monthly worksheet or in the EMR? E25 and E29 did not have a response. They stated that the RD would review the weights and ask for a re-weight. The surveyor asked for the weekly weights worksheets for 12/19 and 1/2020, however, none were provided.

1/15/2020 approximately 2:00 PM - During an interview with E8 (RD), she was informed that the facility failed to identify a 5.4 lb. weight loss for R65 on 10/4/19 and failed to obtain a re-weight. E8 stated that weekly weights were ordered on 12/19/19 and confirmed that there were no weekly weights found. E8 stated that she often has to ask for re-weights to be done or has to clarify that the weights were actual re-weights.

1/16/2020 9:52 AM - During an interview, E29 (UM/LPN) was asked if R65's current wheelchair weight was correctly listed on the Wheelchair Weight list (as R65 had to be weighted in her wheelchair which then had to be deducted from the total weight). According to the RD progress note on 12/18/19, the resident had a wheelchair change on 12/2/19. E29 stated that she believed that it was still the old wheelchair's weight and that she would obtain a new weight.

1/16/2020 approximately 11:00 AM - In an interview, E7 (MD) stated that she was aware of R65's weight loss and that it was being monitored as the resident allows. E7 stated she believes the resident is declining due to her medical conditions.

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F 692	Continued From page 30 The facility failed to ensure that a weight loss was identified on 10/4/19 and that a re-weight was completed. The facility failed to complete subsequent re-weights according to policy and procedure and as ordered. Additionally, the facility failed to complete weekly weights for R65 on three (3) occasions (12/19/19, 12/26/19, and 1/2/2020). 1/16/2020 approximately 4:10 PM - Findings were reviewed with E1 (NHA) and E2 (DON). 1/21/2020 approximately 1:30 PM - Findings were reviewed with E1, E2, E23 (ADON), and E24 (Staff Educator). 2. Review of R94's medical record revealed the following: 12/12/15 - R94 was admitted to the facility. 12/5/19 - R94's monthly weight was documented as 164.8 pounds (#). 12/20/19 - The quarterly MDS assessment documented that R94 had short and long term memory problems, was independent with eating and required set-up of the meal by staff, and weighed 165 #. 1/5/20 - R94's monthly weight was documented as 152.9 # (a difference of 11.9 # from the 12/5/19 weight). There was lack of a re-weight when the surveyor conducted the medical review on 1/8/20. 1/10/20 12:30 PM - The subsequent review of the	F 692		

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F 692	Continued From page 31 facility's electronic medical records documented a re-weight of 163 #. 1/13/20 1:31 PM - An interview with E8 (RD) revealed that she identified the lack of a re-weight on 1/10/20 and requested a weight since she did not see a re-weight. E8 confirmed that the facility failed to complete the re-weight within 24 hours to confirm the weight. Findings were reviewed with E1 (NHA) and E2 (DON) during the Exit Conference beginning at 1:30 PM.	F 692		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review, interview, and review of other facility documents, it was determined that the facility failed to provide pain management in accordance with standards of practice by not assessing resident pain before and after PRN pain medication for one (R47) out of five residents sampled for medication review. Findings include: Cross Refer F689 2002 - Pain management standards by the American Geriatrics Society included: appropriate assessment and management of	F 697		

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F 697	Continued From page 32	F 697		

pain; assessment in a way that facilitates regular reassessment and follow-up; same quantitative pain assessment scales should be used for initial and follow up assessment; set standards for monitoring and intervention; and collect data to monitor the effectiveness and appropriateness of pain management.

May 2016 - The facility policy entitled Pain Management Protocol stated, "...8. The pain assessment and documentation form shall be used (attachment B). Documentation of pain shall include the following:
a. Indicators of pain (verbal or non-verbal assessment).
b. Intensity of pain (pain scale).
c. Location of pain.
d. Interventions (both non-pharmacological and/or pharmacological).
e. Effectiveness of each intervention..."

Review of R47's medical record revealed the following:

4/22/18 - R47 was admitted to the facility with diagnoses including osteoarthritis, neuropathy, and history of a broken pelvic bone.

4/22/18 (original date) - The care plan for pain, with the most recent revision date of 11/12/19, included a goal that R47 would display evidence of pain relief within 30 minutes of onset. Interventions included ongoing assessment of the resident's pain with emphasis on the onset, location, description, intensity of pain and alleviating and aggravating factors; assess for potential side effects; administer pain medication as ordered, evaluate and record effectiveness; and promote proper body alignment.

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F 697	Continued From page 33 10/18/19 6:30 PM - R47 had an unwitnessed fall and subsequently experienced a new onset of pain. A physician's order was obtained to transfer R47 to the hospital for further evaluation. There was lack of evidence of a comprehensive pain assessment related to this new onset of pain prior to the transfer to the hospital. 10/19/19 - R47 returned to the facility with a new L1 compression fracture and a T10 process fracture with an order for narcotic pain medication, Tramadol by mouth every 12 hours for 10 days as needed for severe pain that was a 7-10 on the pain scale. 10/18/19 through 10/31/19 - Review of R47's physicians' orders, eMAR and nursing notes revealed that R47 received 6 doses of PRN Tramadol. All administrations lacked evidence of indicators of pain (verbal or non verbal), intensity of pain (pain scale), location of the pain, interventions, and effectiveness of the intervention, including the pain scale. 1/21/20 9:50 AM - During an interview, E2 confirmed the facility failed to comprehensively assess the pain prior to and after the administration of Tramadol. Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference beginning at 1:30 PM.	F 697		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals	F 761		

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F 761	Continued From page 34 Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and review of facility policies, it was determined that the facility failed to ensure that drugs and biologicals used in the facility were labeled in accordance with currently accepted professional principles, and included the appropriate accessory and cautionary instructions, and the expiration date when applicable for three (3) out of three (3) medication carts reviewed. Findings include: The facility's pharmacy policy 5.3 Storage and Expiration of Medications, Biologicals, Syringes and Needles, last revised 10/31/16, stated, "...4.	F 761		

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F 761	Continued From page 35 Facility should ensure that medications and biologicals that: (1) have an expired date on the label; (2) have been retained longer than recommended by manufacturer or supplier guidelines; or...are stored separate from other medications until destroyed or returned to the pharmacy or supplier. 5. Once any medication or biological is opened, Facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the medication container when the medication has a shortened expiration date once opened. 5.1 Facility staff may record the calculated expiration date based on date opened on the medication container...6. Facility should destroy and reorder medications and biologicals with soiled, illegible, worn, makeshift, incomplete, damaged or missing labels or cautionary instructions...16. Facility should destroy or return all discontinued, outdated/expired, or deteriorated medications...". The facility's pharmacy policy 6.0 General Dose Preparation and Medication Administration, last revised 1/1/13, stated, "...3.3 Facility staff should not administer a medication if the medication or prescription label is missing or illegible...3.11 Facility staff should enter the date opened on the label of medications with shortened expiration dates (e.g., insulins, irrigation solutions, etc.)...3.11.1 Facility staff may record the expiration date based on date opened on the label of medications with shortened expiration dates...". 1. Observation of the 3rd floor medication cart with E6 (LPN) on 1/21/20 at 9:45 AM revealed the following expired medications: - Loperamide HCL (for diarrhea) 2 mg blister	F 761		

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F 761	Continued From page 36 pack - 12 capsules remaining - expired 12/31/19; - Loperamide HCl 2 mg blister pack - 25 capsules remaining - expired 8/31/19; - Loperamide HCl 2 mg blister pack - 13 capsules remaining - expired 8/31/19; - Senna Laxative (for constipation) 8.6 mg tablets blister pack - 20 tablets remaining - expired 11/6/19. All of the above listed medications were for R10. During an interview immediately afterwards, E6 confirmed that the 4 medications were expired. 2. Observation of a 2nd floor medication cart with E23 (ADON) on 1/21/20 at 10:10 AM revealed the following expired medication: - Omeprazole (decreases the amount of acid produced in the stomach) 20 mg capsule DR (delayed release) - 24 tablets remaining - expired 12/31/19 for R45. During an interview immediately afterwards, E23 comfirmed the medication was expired. 3. Observation of a 1st floor medication cart with E28 (LPN) on 1/21/20 at 10:25 AM revealed the following: a. A house stock bottle of Robafen syrup (for cough due to cold) was expired on March 2019. b. A Lantus (insulin-injectable medication used for diabetes) Solostar 100 Unit/ml Prefilled Pen labeled for R44 with an expiration date of 10/31/2021 was placed in a plastic bag that had a written date of 1/21/2020. The Lantus pen itself was not dated with the date it was opened and first used, and did not have the date it expired (as per pharmacy policy).	F 761		

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F 761	Continued From page 37 In an interview immediately afterwards, E28 confirmed the Solostar prefilled pen did not contain dates of when it was opened and when it would expire. c. A Novolog (insulin) Flex Pen and Levemir Pen (insulin) were both in a plastic bag labeled for R156. The Levemir Pen was labeled with R156's name and administration information, but did not note the date it was opened, nor the date it would expire. The Novolog Flex Pen did not contain a label with the resident's name or administration information. Additionally, it did not note the date it was opened, nor the date it would expire. In an interview immediately afterwards, E28 confirmed the findings. The facility failed to ensure that drugs and biologicals used in the facility were labeled in accordance with currently accepted professional principles, and included the appropriate accessory and cautionary instructions. Additionally, the facility failed to remove expired medications. Findings were reviewed with E1 (NHA) on 1/21/20 at approximately 10:45 AM. 1/21/20 at approximately 1:30 PM - Findings were reviewed with E1, E2 (DON), E23 (ADON), and E24 (Staff Educator) during the exit conference.	F 761		

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

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

STATE SURVEY REPORT

NAME OF FACILITY: Kentmere Rehabilitation And Healthcare Center DATE SURVEY COMPLETED: January 21, 2020

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced annual, complaint and emergency preparedness survey was conducted at this facility from January 8, 2020 through January 21, 2020. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other documentation as indicated. The facility census the first day of the survey was 102. The survey sample size was 43 residents.		
3201	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.0	**Scope**		
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:** Cross Refer to the CMS 2567-L survey completed January 21, 2020: F585, F656, F658, F684, F689, F692, F697 and F761.	Cross reference to CMS 2567-L F585, F 656, F658, F684, F689, F692, F697 and F761.	March 6, 2020

Provider's Signature Eileen Malle Title Administrator Date 2/20/2020