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

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

STATE SURVEY REPORT

NAME OF FACILITY: Kentmere Rehabilitation

DATE SURVEY COMPLETED: December 9, 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, complaint and emergency preparedness survey was conducted at this facility from December 1, 2021 through December 9, 2021. 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 ninety three (93). The survey sample size was forty five (45) residents.		
3201.0	**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 the following: Cross Refer to the CMS 2567-L survey completed December 9, 2021: F558, F561, F575, F577, F585, F609, F655, F657, F677, F689, F695, F812, F835, F868 and F880.	Cross reference to CMS 2567-L F558, F561, F575, F577, F585, F609, F655, F657, F677, F689, F695, F812, F835, F868 Cross reference to CMS 2567-L F880	1/07/2022 12/30/2021

Provider's Signature Eileen Malloy Title ADMINISTRATOR Date 12/29/2021

Kentmere Rehabilitation & HealthCare Center

Infection Control Directed Plan of Correction (DPOC)

December 29, 2021

1. A root cause analysis was conduced by the Interdisciplinary team, including, Infection Preventionist/Educator, quality Assurance and Performance Improvement (QAPI) committee, and Governing body.

Problem Statement: The facility failed to implement appropriate infection control practices during a ongoing COVID-19 outbreak

Why:

- COVID unit on the first floor is not separate, distinct and discrete.
- A nurse and CNA are providing direct care to both residents in the COVID unit and non-COVID area.
- The CNA confirmed that she provided direct care to a COVID + resident wearing a surgical mask, not an N95 mask, and continued to provide care afterwards to non-covid residents
- All other direct care staff in the facility were not wearing full PPE during an ongoing outbreak in the facility that does not have a discrete unit according to the DPH and CDC
- Per interviews with the assigned day shift nurse and activity aide, it was confirmed that they are wearing KN95 masks in the rooms with the COVID-19 positive residents.
- All staff have not been trained and fit-tested on the appropriate type of N95 required to be worn when providing direct care to COVID-19 positive residents.

Why:

- Further staff education required
- Facility did not have N95 mask immediate available on the Covid-19 unit

2. All Covid-19 policies and procedures were reviewed. The Covid-19 policy was updated to include Covid-19 zoning and required PPE in the zones. A Respiratory protection program was also implemented.

3. Training of all staff regarding the facility's policy and procedures for Ciovid-19 isolation, setting up zones during outbreak, deployment of staff and proper PPE usage during an outbreak including N95 fitting as referenced in abatement plan and any additional areas identified in the RCA submitted with the 2567 ePOC.

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	085001	A. BUILDING _____ B. WING _____	C 12/09/2021

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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 Emergency Preparedness survey was conducted at this facility beginning December 1, 2021 through December 9, 2021 by the State of Delaware Division of Health Care Quality, Office of Long Term Care Residents Protection in accordance with 42 CFR 483.73. The facility census the first day of the survey was ninety three (93). For the Emergency Preparedness survey, all contracts, operation plans, contact information, and annual emergency drills were up to date. No deficiencies were identified.	E 000		
F 000	INITIAL COMMENTS An unannounced annual, complaint and emergency preparedness survey was conducted at this facility from December 1, 2021 through December 9, 2021. 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 ninety three (93). The survey sample size was forty five (45) residents. Abbreviations/definitions used in this report are as follows: ADON - Assistant Director of Nursing; DSS - Director of Social Services; CNA - Certified Nurse's Aide; DON - Director of Nursing; HCP - Healthcare Personnel; MD - Medical Doctor; NHA - Nursing Home Administrator; PADON - previous Assistant Director of Nursing;	F 000		

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

Electronically Signed | 12/28/2021

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 PDON - previous Director of Nursing; UM - Unit Manager. Bed Mobility - the ability to perform specific movements while in bed; BIMS (Brief Interview for Mental Status) - test to measure thinking ability with score ranges from 0 to 15. 13-15: Cognitively intact 08-12: Moderately impaired 00-07: Severe impairment; Don or Donning- putting on; Extensive Assistance - resident is involved in the activity, staff provide weight-bearing support; MDS assessment - Minimum Data Set/standardized assessment tool used in Long Term Care; PPE (personal protective equipment) - includes gowns, gloves, eye protection and masks for example; QAPI - Quality Assurance Performance Improvement.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview it was determined that for one (R101) out of 45 sampled resident, the facility failed to notify the on-call maintenance staff of a broken call bell. In addition, the facility failed to provide a	F 558	1. The facility cannot retroactively address R101's non-functioning call bell during the time period of 10/2/2021 through 10/4/2021. 2. The facility has determined that all	1/7/22

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F 558	Continued From page 2 tap bell or to conduct more frequent checks on R101 when her call bell was not functioning from 10/2/21 to 10/4/21. Findings include: February 2019 - The facility policy entitled Call Bell Functionality included, "...Maintenance department is available 24/7 to respond to reports of nonfunctioning call bells." February 2019 - The facility procedure entitled Call Bell Functionality included, "In the event that a residents call bell is not functioning, the nursing department will issue the affected resident a tap bell and the resident will be educated on the use of the tap bell. The nursing supervisor will also immediately notify the maintenance department of the non-functioning call bell and need of repair." Cross refer to F585, example #3. Review of R101's clinical record revealed: 9/15/21 - R101 was admitted to the facility for rehabilitation. 9/15/21 - A baseline care plan was initiated for Bowel and Bladder Incontinence and Fall, Safety, and Elopement Risk and both included an intervention to keep the call bell within reach. In addition, the fall care plan included an intervention to encourage the resident to utilize the call bell and wait for staff assistance. 9/22/21 - An Admission MDS (Minimum Data Set) assessment documented that R101 was cognitively intact, alert and oriented and needed extensive assistance for bed mobility, transfers, and toileting.	F 558	residents have the potential to be affected. On 12/9/2021, the maintenance department reviewed the Call Bell monitoring system and assessed all call bells in resident rooms to ensure proper functionality; no issues were identified. 3. A root cause analysis was conducted by the interdisciplinary team and it was identified that a staff member was unaware to immediately notify maintenance for repair of call bell. The facility reviewed the Call Bell Policy (Attachment A) & revised it to reflect that if a call bell is found to be non-functional, the nursing staff will immediately provide resident with a tap bell and notify the maintenance department. The maintenance department is on call 24/7. The Staff Developer/designee will provide in-service education programs for all personnel addressing policies and procedures, regulations, and facility expectations of staff to assure the functionality of call lights in resident rooms at all times. 4. The Assistant Director of Nursing/designee will complete a weekly audit of 10 staff members to ensure that they are aware of and following the Call Bell policy (Attachment B) x 3 weeks. Once results demonstrate 100% compliance for 3 weeks, then monthly audits will be conducted x 3 months or until audit results are 100% x 3 consecutive months. This plan of correction will be monitored at the quarterly Quality Assurance meeting until substantial compliance has been met.	

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F 558	Continued From page 3 9/30/21 - A Care Conference note documented that R101 "...is ambulating 150 feet with a rolling walker with supervision. She transfers with contact guard/min [minimal] assistance...". 10/2/21 - 10/4/21 - A review of R101's chart revealed no documentation related to the broken call bell. 12/6/21 2:20 PM - During an interview, E26 (Maintenance Director) confirmed that E12 (previous DON) should have called him on 10/2/21 when R101 told him that her call bell was not working and there was no ticket or work order sent to Maintenance to fix R101's call bell. 12/8/21 1:00 PM - During a phone interview, E27 (CNA) stated that she remembers the incident when R101's call bell was not working, but she does not remember the CNA's being told to check on R101 more often. When asked what the procedure was when a resident's call bell does not work, she stated to notify the Nurse or Supervisor. 12/8/21 2:45 PM - During a phone interview, R101 stated that on October 2, 2021 (Saturday) she reported that her call bell was not working to E12 (previous DON) and to one of the nurses (R101 does not remember her name) on her unit. E12 told R101 that "Someone would check on her every hour and that he would put in a maintenance ticket." R101 stated that she was not checked on every hour by staff (from Saturday afternoon to Monday morning). In addition, R101 stated she was in a private room and was not provided a tap bell or other means to call staff for help. On Monday morning (10/4/21)	F 558		

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F 558	Continued From page 4 her call bell had not been fixed, so she called E26 (Maintenance Director) herself. E26 fixed the call bell immediately and told her that he was glad she called him because not one reported it to him. E26 stated that he would have come in on Saturday to fix the broken call bell if he'd known. 12/8/21 4:07 PM - E11 (NHA), E2 (DON), and E6 (DSS and Grievance Officer) were asked to provide documentation that the facility monitored R 101 when her call bell was broken and a submitted maintenance request to have the call bell repaired on 10/2/21. The facility did not provide any information. 12/9/21 7:11 AM - An email from E11 was received, but the facility did not provide any documentation to show that Maintenance was called in on 10/2/21 or that R101 was provided a tap bell or checked every hour while her call bell was broken. Findings were reviewed with E1 (NHA) and E2 (DON) during the Exit Conference on 12/9/21, beginning at 1:00 PM.	F 558		
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 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	F 561		1/7/22

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F 561	Continued From page 5 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 (R41) out of one resident reviewed for choices, the facility failed to ensure the resident's right to make choices about aspects of their life in the facility that were significant to R41. Findings include: Review of R41's clinical record revealed: 12/22/20 - An annual MDS assessment documented R41 as being alert and oriented, requiring supervision and set up help for bathing and the preference to choose between a tub bath, shower, bed bath and sponge bath were very important. R41's care plan for bathing/showering last updated 10/7/21, indicated the resident required supervision with set up by one staff member with	F 561	1. R41 was interviewed to determine his shower preferences and his shower schedule was adjusted to meet his preferences. 2. The facility has determined that all residents have the potential to be affected. By 12/28/2021, all cognitively appropriate residents were interviewed to ensure their shower preferences were being honored; adjustments to the plans of care made as appropriate. 3. A root cause analysis was conducted by the interdisciplinary team and it was identified that there was not a consistent process in place to identify residents bathing preferences. The facility reviewed the Resident Self Determination and Participation Policy (Attachment C) and revised it to reflect that upon admission,	

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F 561	Continued From page 6 showering twice a week and as necessary. Review of the CNA task documentation for R41 revealed bathing preferences documented as "showers" with R41 receiving a shower twice a week during day shift on Wednesdays and Saturdays. During an interview on 12/1/21 at 1:43 PM, R41 stated, "I wish I could get more showers, like daily. I asked and they said 'dream on'." 12/8/21 9:42 AM - R41 was observed sitting in a wheelchair wearing a bathrobe. R41 confirmed he was waiting for staff to shower him and stated, "I like it every day or every other day, but they only allow it twice a week." During an interview on 12/8/21 at 9:50 AM, E17 (CNA) confirmed that R41 received a shower twice a week. When asked if R41 could receive daily showers, E17 replied "I'm not sure". During an interview on 12/8/21 at 10:02 AM, E16 (LPN) confirmed that residents received showers twice a week and were not offered additional showers. During an interview on 12/8/21 at 10:10 AM E15 (RN unit manager for R41's unit) confirmed that the facility lacked a system for assessing residents preferences for the frequency of showers. E15 stated, "They are offered a shower twice a week. If they asked for more it could be discussed at care plan meeting." Findings were reviewed with E1 (NHA) and E2 (DON) during the Exit Conference on 12/9/21, beginning at 1:00 PM.	F 561	quarterly, and as needed, the resident will be evaluated to determine bathing preferences. The Staff Developer/designee will provide in-service education programs for all direct care personnel addressing regulations, and facility expectations of staff to assure the residents bathing preferences are being honored. 4. The Assistant Director of Nursing/designee will complete a random weekly audit of 10 residents to assure compliance that shower/bathing preferences are being honored x 3 weeks (Attachment D). Once results demonstrate 100% compliance for 3 weeks, then monthly audits will be conducted x 3 months or until audit results are 100% x 3 consecutive months. This plan of correction will be monitored at the quarterly Quality Assurance meeting until substantial compliance has been met.	

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F 575 SS=E	Required Postings CFR(s): 483.10(g)(5)(i)(ii) §483.10(g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives: (i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and (ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to post a list of names, addresses (mailing and email), and telephone numbers of the State Survey Agency, the State licensure office, the Office of the State Long-Term Care Ombudsman program, and the telephone numbers of the Division of Health Care Quality's (DHCQ) abuse reporting hotline number. In addition, the facility failed to post a statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of State or Federal nursing facility	F 575	1. The facility acknowledges that the required information was not posted and posted it immediately. 2. The facility has determined that all residents have the potential to be affected by this information not being posted and ensured that the required information was posted on 12/7/2021. 3. A root cause analysis was conducted by the interdisciplinary team and it was identified that the postings were in the process of being updated. The Staff	1/7/22

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F 575	Continued From page 8 regulations. Findings include: 12/7/21 2:10 PM to 2:40 PM - An observation of the facility's lobby, hallways, resident units, and common areas of all four floors revealed the absence of postings of contact information for the State Survey Agency, the Division of Health Care Quality's (DHCQ) abuse reporting hotline number, and the Long Term Care Ombudsman. There was also no posting regarding the filing of a complaint with the State Survey Agency. 12/7/21 2:45 PM - During an interview with E1 (NHA) and E6 (DSS and Grievance Officer), E1 confirmed that the above required information was not posted in the facility. E1 stated they were updating the information and will post today. Findings were reviewed with E1 (NHA) and E2 (DON) during the Exit Conference on 12/9/21, beginning at 1:00 PM.	F 575	Developer/designee will provide an in-service education program for all administrative personnel addressing the regulation and facility expectations to assure the residents have access to the required information. 4. The Social Service Director/designee will complete a weekly audit (Attachment E) to assure compliance with required postings x 3 weeks. Once results demonstrate 100% compliance for 3 weeks, then monthly audits will be conducted x 3 months or until audit results are 100% x 3 consecutive months. This plan of correction will be monitored at the quarterly Quality Assurance meeting until substantial compliance has been met 01/07/2022	
F 577 SS=E	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility.	F 577		1/7/22

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F 577	Continued From page 9 (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to have survey results from the past three years available for residents, family members and legal representatives to review. Findings include: 12/6/21 1:20 PM - A random observation of the front lobby revealed a binder which contained the survey results on a table between a sofa and chairs. Review of the reports found that neither of the 2021 (7/7/21 and 8/26/21) survey reports were in the binder. 12/6/21 1:30 PM - During an interview, E1 (NHA) confirmed the facility's binder for survey results did not contain survey results from the past three years. E1 stated that she will update the binder with the 2021 survey reports today. Findings were reviewed with E1 and E2 (DON) during the Exit Conference on 12/9/21, beginning at 1:00 PM.	F 577	1. The facility acknowledges that the required survey findings for the preceding 3 years were not available for residents, family members, and legal representatives to review, and made them available immediately. 2. The facility has determined that all residents, family members, and legal representatives have the potential to be affected by this information not being available and ensured that the required information was made available on 12/6/2021. 3. A root cause analysis was conducted by the interdisciplinary team and it was identified that the most recent survey results were not placed in the binder related to a designated individual not specifically assigned to that task. The Administrator/designee will be assigned the responsibility of ensuring the most recent survey results are available and placed in the binder. The Quality Assurance Coordinator/designee will provide an in-service education program for the administrative personnel	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENTMERE REHABILITATION AND HEALTHCARE CENTER	1900 LOVERING AVENUE WILMINGTON, DE 19806

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F 577	Continued From page 10	F 577	addressing the regulation and facility expectations of assuring the residents, family members, and legal representatives have access to the required information. 4. The Quality Assurance Coordinator/designee will complete a weekly audit (Attachment F) to assure compliance with all survey findings for the preceding 3 years are available x 3 weeks. Once results demonstrate 100% compliance for 3 weeks, then monthly audits will be conducted x 3 months or until audit results are 100% x 3 consecutive months. This plan of correction will be monitored at the quarterly Quality Assurance meeting until substantial compliance has been met	
F 585 SS=E	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 accordance with this paragraph.	F 585		1/7/22

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F 585	Continued From page 11 §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 written grievance decisions to the resident; and	F 585		

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F 585	Continued From page 12 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 record review, interview, observation, and review of facility policies, it was determined	F 585	1. 1. The facility acknowledged that the	

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F 585	Continued From page 13 that the facility failed to make prompt efforts to resolve grievances for two (R101 and R299) out of four residents investigated for grievances. In addition, it was determined that the facility failed to implement a grievance policy and postings that included a process for residents and families to file anonymous grievances and to identify the Grievance Official. Findings include: 1. Grievance Policy: September 2020 (last revised) - Review of the facility's Grievance policy revealed "The facility will make information on how to file a grievance or complaint available to residents ...shall include: ...the right to file grievances anonymously; the contact information for the grievance official ..." however, the following required information was not included: - the procedures for filing resident grievances anonymously, and - the current Grievance Official's name (E6 DSS) and contact information with whom a grievance can be filed. 12/7/21 2:45 PM - During an interview, the above findings were reviewed with E1 (NHA). 2. Postings: 12/7/21 2:10 PM to 2:40 PM - An observational inspection of the facility lobby, hallways, resident units, and common areas of all four floors revealed the absence of postings of the procedure for filing resident grievances anonymously and the current Grievance Official's name (E6 DSS) and contact information. 12/7/21 2:45 PM - During an interview with E1	F 585	Grievance policy did not include the process for filing grievances anonymously or the Grievance officer's name. 2. The facility has determined that all residents have the potential to be affected. 3. A root cause analysis was conducted by the interdisciplinary team and it was identified that upon review of the Grievance policy, the facility did not include the process for filing grievances anonymously or the Grievance Officer's name. The facility reviewed and revised the Grievance Policy (Attachment G) to include the process for filing grievances anonymously and to include the Grievance officer's name. A grievance box was also placed outside of the Social Service Director's office. The Staff Developer/designee will provide in-service education programs for all staff addressing policies and procedures, regulations, and facility expectations of staff to assure that residents, family members, and legal representatives know the procedure for filing a grievance anonymously, as well as the Grievance Officers name. 4. The Social Service Director/designee will complete a random weekly audit (Attachment H) of 10 residents and/or family members/legal representatives to assure compliance with residents, family members, and/or legal representatives understanding the process for filing grievances anonymously and the Grievance officer's name x 3 weeks. Once results demonstrate 100%	

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F 585	Continued From page 14 (NHA) and E6 (DSS and Grievance Officer), E1 confirmed the above required information was not posted in the facility. E1 stated they were updating the information and will post it today. 3. Cross refer to F558. Review of R101's clinical record revealed: 9/15/21 - R101 was admitted to the facility for rehabilitation. 9/15/21 - Baseline care plans were initiated for Bowel and Bladder Incontinence and Fall, Safety, and Elopement Risk and both included an intervention to keep the call bell within reach. In addition, The fall care plan included an intervention to encourage the resident to utilize the call bell and wait for staff assistance. 9/22/21 - An Admission MDS (Minimum Data Set) assessment documented that R101 was cognitively intact and needed extensive assistance for bed mobility, transfers, and toileting. 9/30/21 - An Interdisciplinary Admission Care Conference note documented that R101 "...is ambulating 150 feet with a rolling walker with supervision. She transfers with contact guard/min [minimal] assistance...She had a UA [urine lab test to check for infection] completed and is waiting for the results." E6 (DSS and Grievance Officer), E12 (PDON), E18 (Director of Rehabilitation), R101 attended the meeting at the facility and FM4 (family member) attended by phone. 10/27/21 - R101 was discharged from the facility	F 585	compliance for 3 weeks, then monthly audits will be conducted x 3 months or until audit results are 100% x 3 consecutive months. This plan of correction will be monitored at the quarterly Quality Assurance meeting until substantial compliance has been met. 2 1. The facility acknowledged that postings of how to file an anonymous grievance and who the grievance officer is, was not on all floors. 2. The facility has determined that all residents have the potential to be affected. by not being aware of the process of reporting grievances anonymously or not being aware of who the grievance officer is. This information was immediately posted on each floor and by 12/30/2021, all residents, family members, and legal representatives were educated on the grievance process. 3. A root cause analysis was conducted by the interdisciplinary team and it was identified that the facility did not post the information. The Staff Developer/designee will provide an in-service education program for all administrative personnel addressing the regulation and facility expectations of assuring the residents, family members, and legal representatives have access to the required information. 4. The Social Service Director/designee will complete a weekly audit (Attachment H) to assure compliance with the required	

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F 585	Continued From page 15 to home. 12/7/21 9:30 AM - During an interview, E6 (DSS and Grievance Officer) stated the facility had no record of any grievances, incidents, or medication errors for R101. 12/8/21 2:45 PM - During a phone interview, R101 stated: a. In the beginning of her stay at the facility, she accidentally dropped the pills E25 (LPN) had given her, then E25 picked the pills up off the floor and gave them to her to take. Although she was shocked and concerned, she swallowed the pills. Later she reported it to E6. Because it did not happen again, R101 said she assumed it was addressed, but she never received any feedback from E6. b. R101 reported to E6 (DSS and Grievance Officer), E12 (PDON), and E18 (OT, Director of Rehabilitation) in the 9/30/21 interdisciplinary care plan meeting that several of the CNAs were wiping back to front while doing incontinence care and the team agreed to provide education on incontinence care to all CNAs on her unit. c. On October 2, 2021 (Saturday) she reported that her call bell was not working to E12 and to one of the nurses on her unit. E12 told R101 that "Someone would check on her every hour and that he would put in a maintenance ticket." On Monday morning (October 4, 2021) her call bell not been fixed, so she called E26 (Maintenance Director) herself. E26 fixed the call bell immediately and told her that he was glad she called him because not one reported it to him. E26 stated that he would have come in on	F 585	postings x 3 weeks. Once results demonstrate 100% compliance for 3 weeks, then monthly audits will be conducted x 3 months or until audit results are 100% x 3 consecutive months. This plan of correction will be monitored at the quarterly Quality Assurance meeting until substantial compliance has been met. 3. 1. The facility cannot retroactively document on or respond to R101's grievances. 2. The facility has determined that all residents have the potential to be affected. 3. A root cause analysis was conducted by the interdisciplinary team and it was identified that a staff member was unaware of the policy. The Staff Developer/designee will provide an in-service education program for all personnel addressing the regulation and facility expectations of assuring the residents, family members, and legal representatives grievances are documented appropriately on the Grievance form. 4. The Social Service Director/designee will complete a weekly audit (Attachment H) of 10 staff members to determine if they have received any grievances and documented all grievances from residents, family members, and/or legal representatives to assure compliance x 3 weeks. Once results demonstrate 100% compliance for 3 weeks, then monthly	

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F 585	Continued From page 16 Saturday to fix the broken call bell if he'd known. 12/8/21 4:07 PM - E1 (NHA), E2 (DON), and E6 (DSS and Grievance Officer) were asked to provide any evidence that the facility documented and acted on R101's three complaints, however, they did not provide any further documentation. 4. Review of R299's clinical records, the facility's email record, and staff interview revealed the following: 12/24/20 - R299 was admitted to the facility. 7/1/21 - The Quarterly MDS Assessment stated that R299 was independent with daily decision making and required extensive assistance of two plus staff persons for toileting. 8/6/21 through 9/7/21 - Email provided by the facility during the survey revealed: - 8/6/21 11:12 AM: An email from R299's family member (FM1) to E6 (DSS) documented concerns for lack of toileting assistance, lack of a shower and lack of prompt assistance to remove R299 from a bedpan the evening of 8/5/21. - 8/6/21 11:41 AM: An email response from E6 to FM1 documented that E6 forwarded the concerns to E12 (PDON) and E5 (PADON) and that E12 and E5 would investigate the concerns and follow-up with FM1. - 8/23/21 11:09 AM: An email from FM1 indicated that R299's family had not heard anything in reference to the facility's investigation. - 8/23/21 11:21 AM: An email from E6 (DSS) to	F 585	audits will be conducted x 3 months or until audit results are 100% x 3 consecutive months. This plan of correction will be monitored at the quarterly Quality Assurance meeting until substantial compliance has been met. 4. 1. The facility cannot retroactively respond to R299's grievances. 2. The facility has determined that all residents have the potential to be affected. 3. A root cause analysis was conducted by the interdisciplinary team and it was identified that a staff member was unaware of the policy. The facility reviewed the Grievance Policy (Attachment G) and the Staff Developer/designee will provide in-service education programs for all administrative staff responsible for responding to grievances, addressing policies and procedures, regulations, and facility expectations of staff to assure timely responses to residents, family members, and legal representatives grievances. 4. The Social Service Director/designee will complete a weekly audit (Attachment H) of all filed grievances to assure timely response and resolution of the grievance x3 weeks. Once results demonstrate 100% compliance for 3 weeks, then monthly audits will be conducted x 3 months or until audit results are 100% x 3 consecutive months. This plan of correction will be monitored at the quarterly Quality Assurance meeting until	

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F 585	Continued From page 17 FM1 stated that she communicated the concerns to E12 (ADON) and E6 was waiting for a response. -8/24/21 2:00 PM: An email from FM1 to E6 (DSS) included FM1's telephone number for the facility to contact him. - 9/3/21 12:26 PM: An email from FM2 (R299's Family Member 2) was sent to the State of Delaware Long Term Care Ombudsman (LTCO) requesting assistance from LTCO regarding the concerns communicated to the facility on 8/6/21 since the facility did not follow up with FM1. 12/8/21 9:25 AM - An interview with E6 (DSS) revealed that she was the designated Grievance Officer. E6 confirmed that although the facility was aware of the concerns by R299's family members on 8/6/21 and the family subsequently communicated to the LTCO on 9/7/21, the facility failed to act promptly to the grievance. Findings were reviewed with E1 (NHA) and E2 (DON) during the Exit Conference on 12/9/21, beginning at 1:00 PM.	F 585	substantial compliance has been met.	
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2	F 609		1/7/22

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F 609	Continued From page 18 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of other facility documentation as indicated, it was determined that the facility failed to identify and report an allegation of neglect or abuse to the State Agency for two (R65 and R299) out of three (3) sampled residents reviewed for abuse/neglect. Findings include: October 2019 - Review of the facility policy entitled Abuse, Neglect, Mistreatment, Misappropriation, Exploitation and Reasonable Suspicions of Crime, stated, "...Neglect is the failure of the facility, its employees or services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress and include lack of attention to physical needs of the resident...".	F 609	1. 1. The facility does not have the ability to retroactively address the unmet reporting requirements for R299. 2. The facility has determined that all residents have the potential to be affected by failing to report allegations of abuse, neglect, exploitation, or mistreatment. 3. A root cause analysis was conducted by the interdisciplinary team and it was identified that a staff member was unaware of the policy. The facility reviewed the Abuse Policy and the Staff Developer/designee will provide in-service education programs for all personnel addressing policies and procedures,	

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F 609	Continued From page 19 Cross refer F585, Example #4. Cross refer F677, Example #1. 1. Review of R299's clinical records and staff interview revealed the following: 12/24/20 - R299 was admitted to the facility. 7/1/21 - The Quarterly MDS Assessment stated that R299 was independent with daily decision making and required extensive assistance of two plus staff persons for toileting. 8/6/21 through 9/7/21 - Email provided by the facility during the survey revealed: - 8/6/21 11:12 AM: An email from R299's family member (FM1) to E6 (DSS) documented concerns for lack of toileting assistance, lack of a shower and lack of prompt assistance to remove R299 from a bedpan the evening of 8/5/21. - 8/6/21 11:41 AM: An email response from E6 to FM1 documented that E6 forwarded the concerns to E12 (PDON) and E5 (PADON) and that E12 and E5 would investigate the concerns and follow-up with FM1. - 8/23/21 11:09 AM: An email from FM1 indicated that R299's family had not heard anything in reference to the facility's investigation. - 8/23/21 11:21 AM: An email from E6 (DSS) to FM1 stated that she communicated the concerns to E12 (ADON) and E6 and was waiting for a response. -8/24/21 2:00 PM: An email from FM1 to E6 (DSS) included FM1's telephone number for the	F 609	regulations, and facility expectations of staff to assure that all allegations of abuse, neglect, exploitation, or mistreatment are reported to the State Agency in a timely manner. 4. The Assistant Director of Nursing/designee will complete a weekly audit (Attachment I) of 10 staff members to assure compliance with reporting resident, family member, or legal representatives' allegations of abuse, neglect, exploitation, or mistreatment x 3 weeks. Once results demonstrate 100% compliance for 3 weeks, then monthly audits will be conducted x 3 months or until audit results are 100% x 3 consecutive months. This plan of correction will be monitored at the quarterly Quality Assurance meeting until substantial compliance has been met. 2. 1. The facility does not have the ability to retroactively address the unmet reporting requirements for R14 and R65. 2. The facility has determined that all residents have the potential to be affected by failing to report allegations of abuse, neglect, exploitation, or mistreatment to the appropriate state regulatory authority within 2 hours. 3. A root cause analysis was conducted by the interdisciplinary team and it was identified that a staff member was unaware of the policy. The facility reviewed the Abuse Policy and the Staff Developer/designee will provide in-service	

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F 609	Continued From page 20 facility to contact him. - 9/3/21 12:26 PM: An email from FM2 (R299's Family Member 2) was sent to the State of Delaware Long Term Care Ombudsman (LTCO) requesting assistance from LTCO regarding the concerns communicated to the facility on 8/6/21 since the facility did not follow up with FM1. In addition, FM2 stated earlier during the week, R299 was left in a dirty adult brief for an extended period of time. 12/8/21 12:50 PM - During an interview with E6 (DSS), the Surveyor reviewed the above policy and procedure and asked E6 if she would consider the complaint made by R299's family as an allegation of neglect. E6 stated that she would have to review the complaint and follow-up with the Surveyor. E6 did not follow-up with the Surveyor during the survey. The facility failed to identify and immediately report an allegation of neglect on 8/6/21 when R299's family member (FM1) emailed E6 (DSS) a grievance in which R299 was not provided incontinence care, a shower, and delayed removing R299 from the bedpan on 8/5/21. Despite E6 receiving an email dated 9/7/21 from the State of Delaware LTCO regarding the above complaint and an additional complaint by FM2 for lack of incontinence care during the week of 9/7/21, the facility failed to identify and immediately report an allegation of neglect. 12/9/21 Approximately 10:00 AM - During an interview with E2 (DON), the above findings were reviewed and E2 confirmed that lack of incontinence care and a shower would be considered allegations of neglect, thus, the facility	F 609	education programs for all direct care personnel addressing policies and procedures, regulations, and facility expectations of staff to assure that all allegations of abuse, neglect, exploitation, or mistreatment are reported to the State Agency in a timely manner. Education included the definition of abuse, neglect, exploitation, and mistreatment, as well as the timeframe on reporting these allegations to the State Agency. 4. The Assistant Director of Nursing/designee will complete a weekly audit (Attachment I) of all reported allegations to assure they are reported within the two hour time frame following the notification of the allegation x 3 weeks. Once results demonstrate 100% compliance for 3 weeks, then monthly audits will be conducted x 3 months or until audit results are 100% x 3 consecutive months. This plan of correction will be monitored at the quarterly Quality Assurance meeting until substantial compliance has been met.	

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F 609	Continued From page 21 failed to identify and report this to the State Agency. 2. The facility's Abuse policy, effective October 2019, stated under Reporting and Response " ...Allegations of resident abuse shall be reported to the appropriate state regulatory authority within 2 hours." 12/3/21 - Review of the facility's Incident Report, dated 5/24/21 at 3:09 PM, submitted by E5 (previous ADON), revealed that on 5/22/21 at 12:00 AM Resident A (R14) was witnessed pushing resident B (R65) which caused resident B (R65) to fall while ambulating with a rollator (a rolling walker with a seat). There were no apparent injuries to either resident. Further review of facility documentation revealed that both R14 and R65 had a diagnosis of dementia. According to the facility's records, the incident occurred at midnight on 5/22/21 when R14 self-propelled her wheelchair into R65's room and began taking R65s belongings. When R65 attempted to stop R14, R14 pushed R65 which caused R65 to fall. 12/3/21 - The facility's Incident Report was sent to the State agency on 5/24/21 at 3:09 PM, approximately 63 hours after the incident occurred. 12/3/21 1:40 PM - Interview with E4 (RN Infection Control), who was the DON at the time of the incident, confirmed that the facility's Incident Report was prepared on 5/22/21, but the incident was reported to the State Agency after the two hour required reporting time.	F 609		

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F 655	Continued From page 22	F 655		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident.	F 655		1/7/22

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F 655	Continued From page 23 (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for two (R91 and R152) out of two newly admitted residents reviewed, the facility failed to ensure that the baseline care plan was developed within 48 hours of the resident's admission and failed to have evidence that the resident/responsible party was provided the baseline care plan summary. Findings include: 1. Review of R91's clinical record revealed: 11/2/21 - R91 was admitted to the facility. 12/3/21 - Review of R91's care plans lacked evidence of completion of a baseline care plan within 48 hours of admission. Initial comprehensive care plans were created on 11/12/21 and 11/13/21, 10 days after R91's admission. During an interview on 12/6/21 at 11:47 AM, E10 (RNAC) confirmed that the facility lacked evidence the baseline care plan was completed for R91 and the earliest care plan created was 11/12/21. 2. Review of R152's clinical records revealed the following: 11/25/21 - R152 was admitted to the facility with	F 655	1. The facility does not have the ability to retroactively address the failure to initiate a baseline care plan for R91 and R152. 2. The facility has determined that all newly admitted residents have the potential to be affected. An audit of all residents admitted from 12/1/2021 to present was completed; no issues identified. 3. A root cause analysis was conducted by the interdisciplinary team and it was identified that the admitting nurse did not thoroughly complete the admission process, to include a Baseline Care Plan. The facility developed a Baseline Care Plan Policy (Attachment J) and the Staff Developer/designee will provide in-service education program for all licensed nurses on the facility's policy and procedure for developing Baseline Care Plans. 4. The Assistant Director of Nursing/designee will complete a weekly audit (Attachment K) of all residents admitted that week to assure compliance with the initiation of the Baseline Care Plan x 3 weeks. Once results demonstrate 100% compliance for 3	

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F 655	Continued From page 24 diagnoses including dementia and was alert and oriented to herself only. 12/7/21 2:10 PM - Review of R152's records revealed a lack of evidence that a baseline care plan was developed within 48 hours after R152's admission to the facility on 11/25/21. 12/7/21 2:16 PM - During an interview, E10 (RNAC)confirmed that the facility lacked evidence that a baseline care plan was developed within 48 hours after R152's admission to the facility on 11/25/21. 12/8/21 9:00 AM - Findings were discussed with E2 (DON). Findings were reviewed with E1 (NHA) and E2 (DON) during the Exit Conference on 12/9/21, beginning at 1:00 PM.	F 655	weeks, then monthly audits will be conducted x 3 months or until audit results are 100% x 3 consecutive months. This plan of correction will be monitored at the quarterly Quality Assurance meeting until substantial compliance has been met.	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (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).	F 657		1/7/22

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F 657	Continued From page 25 An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that for one (R53) out of two sampled residents for care plan review, the facility failed to ensure that the care plan was prepared by an IDT (Interdisciplinary Team) that included the Attending Physician or his/her designee, the Nurse's Aide with responsibility for the resident and a staff member from Nutrition/Food Service. Findings include: The following was reviewed in R53's clinical record: 7/7/21- R53 was admitted to the facility. 7/22/21 - Review of the Care Plan Meeting Progress Note lacked evidence that R53's Attending Physician or designee, the Nurse's Aide responsible for the resident and a staff member from Nutrition/Food Service participated in the IDT care planning process. 7/22/21 & 10/25/21 - Review of the Care Plan Meeting Progress Note lacked evidence that R53's Attending Physician or designee, the	F 657	1. The facility does not have the ability to retroactively address the lack of participation in the care planning process for R53 on 7/22/2021 and 10/25/2021. 2. The facility has determined that all residents have the potential to be affected. 3. A root cause analysis was conducted by the interdisciplinary team and it was identified that there was not a system in place to identify that all required staff members participated in the preparation, review, and revision of the residents' care plans. The facility reviewed the Care Plan Policy and are implementing a Interdisciplinary Care Plan Meeting Attendance Record (Attachment L). The Staff Developer/designee will provide an in-service education program for all interdisciplinary care plan team members responsible for participating in the preparation, review, and revision of the residents' care plans on the Meeting	

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F 657	Continued From page 26 Nurse's Aide responsible for the resident and a staff member from Nutrition/Food Service participated in the IDT care planning process. 12/3/21 12:03 PM - An interview with E10 (RNAC) confirmed that R53's Attending Physician (E9), the Registered Dietician or staff from Food Services, and the CNA assigned to R53 were not invited, thus, did not attend the care plan meeting. 12/3/21 12:30 PM - An interview with E6 (DSS) revealed that R53's Attending Physician (E9) and E11 (RD) were invited to the 7/22/21 IDP Care Plan meeting, but were unable to attend. The CNA assigned to R53 was not invited. 12/3/21 1:00 PM - An interview with E11 (RD) revealed that upon request, she attends the IDT Care Plan meetings, but does routinely receive invitations for the meetings. E11 stated it may be because she does not work full time at the facility. Findings were reviewed with E1 (NHA) and E2 (DON) during the Exit Conference on 12/9/21, beginning at 1:00 PM.	F 657	attendance record. 4. The Assistant Director of Nursing/designee will complete a weekly audit (Attachment M) of all resident's care plans for that week to assure compliance with the required staff members in the preparation, review, and revision of the care plan x 3 weeks. Once results demonstrate 100% compliance for 3 weeks, then monthly audits will be conducted x 3 months or until audit results are 100% x 3 consecutive months. This plan of correction will be monitored at the quarterly Quality Assurance meeting until substantial compliance has been met.	
F 677 SS=E	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 observations, interviews and record reviews, it was determined that the facility failed to ensure that activities of daily living (ADL)	F 677	1. 1. The facility does not have the ability to retroactively address the lack of evidence	1/7/22

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F 677	Continued From page 27 related to showers and/or baths, including nail care were provided to two (R91 and R299) dependent residents out of six (6) sampled residents for ADL investigations. Findings include: Cross refer F585, Example #4. Cross refer F609, Example #1. 1. Review of R299's clinical records and staff interview revealed the following: 12/24/20 - R299 was admitted to the facility. 4/6/21 - A care plan for assistance with daily living documented that R299 required extensive assistance of one staff person with bed mobility, toileting and hygiene related to impaired mobility and weakness. Interventions included to provide assistance with daily sponge baths and twice a week tub baths/showers and to assist with toileting as necessary. 7/1/21 - The Quarterly MDS Assessment stated that R299 was independent with daily decision making, required total assistance of two staff persons for bathing and required extensive assistance of two staff persons for toileting. a. 7/2021- Review of the CNA Documentation Record for "Bathing" documented that one shower was provided on 7/5/21, although scheduled on Mondays and Thursdays each week. There was lack of evidence that the facility offered remaining seven (7) scheduled showers were offered to R299. In addition, record review lacked evidence of any bathing provided to R299, including sponge baths for this period of time.	F 677	regarding Bathing and Assistance with toileting for resident R299 during July and August 2021. 2. The facility has determined that all residents have the potential to be affected. 3. A root cause analysis was conducted by the interdisciplinary team and it was identified that the certified nursing assistants failed to complete the required documentation. The facility developed a Documentation Policy (Attachment N) and the Staff Developer/designee will provide an in-service education program for all certified nursing assistants to ensure that policies and procedures, regulations, and facility expectations of staff are met in regards to providing and documenting care of residents. 4. The Unit Manager/designee will complete a weekly audit (Attachment O) of 10 resident's flow sheets to assure compliance with the required care and documentation x 3 weeks. Once results demonstrate 100% compliance for 3 weeks, then monthly audits will be conducted x 3 months or until audit results are 100% x 3 consecutive months. This plan of correction will be monitored at the quarterly Quality Assurance meeting until substantial compliance has been met. 2. A 1. The facility does not have the ability to retroactively address the lack of nail care provided to R91 on 12/1/2021 and	

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F 677	Continued From page 28 8/2021- Review of the CNA Documentation Record for "Bathing" documented that one bed bath was provided on 8/2/21, although scheduled on Mondays and Thursdays each week. There was lack of evidence that the facility offered showers for the month of 2021. In addition, record review lacked evidence of any bathing provided to R299, including sponge baths for this period of time. 8/6/21 - A copy of an email was provided by the facility to the Surveyor during the survey which revealed that R299's family member (FM1) sent an email to E6 (DSS), the facility's Grievance Officer, which documented concern of lack of shower on 8/5/21. 12/9/21 10:32 AM - During an interview with E2 (DON), the above findings were reviewed. E2 responded if showers were offered and refused, it would be documented in the progress notes. Otherwise, documentation of R299 being showered would be documented on the CNA Documentation Record and confirmed the findings of lack of evidence of showers as noted above in 7/2021 and 8/2021. The Surveyor stated there were no refusals of showers documented in the progress notes. b. 7/2021 - Review of the CNA Documentation Record for "Bladder Continence" revealed lack of evidence that assistance with toileting was provided for six (6) out of 31 days (7/7/21, 7/11/21, 7/22/21, 7/23/21, 7/24/21 and 7/29/21). 8/2021 - Review of CNA Documentation Record for "Bladder Continence" revealed lack of evidence that assistance with toileting was provided for six (6) out of 30 days (8/3/21,	F 677	12/2/2021. 2. The facility has determined that all residents have the potential to be affected. An audit of all residents was completed on 12/27/2021 and all nail care concerns addressed immediately. 3. A root cause analysis was conducted by the interdisciplinary team and it was identified that one Certified nursing assistant did not incorporate nail care as a part of daily personal hygiene. The Staff Developer/designee will provide an in-service education program for all certified nursing assistants to ensure that nail care is provided daily with AM and PM care and as needed throughout the day. 4. The Assistant Director of Nursing/designee will complete a weekly audit (Attachment O) of 10 resident's nails to assure compliance with the required care x 3 weeks. Once results demonstrate 100% compliance for 3 weeks, then monthly audits will be conducted x 3 months or until audit results are 100% x 3 consecutive months. This plan of correction will be monitored at the quarterly Quality Assurance meeting until substantial compliance has been met. 2. B 1. The facility does not have the ability to retroactively address the soiled clothing on R91 on 12/1/2021 and 12/2/2021. 2. The facility has determined that all residents have the potential to be affected. An audit of all residents was	

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F 677	Continued From page 29 8/10/21, 8/11/21, 8/18/21, 8/21/21 and 8/29/21). In addition, there was lack of evidence that toileting assistance was provided on 8/5/21, during the day shift from 7:00 AM to 3:00 PM, the date and shift that R299's family members, FM1 and FM2 alleged that R299 was not provided the necessary care. 8/6/21 - A copy of an email was provided by the facility to the Surveyor during the survey which revealed that R299's family member (FM1) sent an email to E6 (DSS) that documented concerns for lack of toileting assistance during day shift on 8/5/21, as well as lack of prompt assistance to remove R299 from a bedpan on the evening of 8/5/21. 12/9/21 10:32 AM - During an interview with E2 (DON), E2 confirmed the lack of evidence that R299 was toileted during day shift (7:00 AM to 3:00 PM) on 8/5/21 and E2 stated the facility was unable to determine which CNA was assigned to R299 during this shift. Additionally, E2 confirmed that there was lack of evidence that R299 was toileted on the above six (6) dates in both July 2021 and August 2021. 2. Review of R91's clinical record revealed: 11/9/21- An admission MDS assessment documented R91 required extensive assistance of one staff member for dressing and hygiene, which included nail care. 11/13/21 - A care plan for assistance with ADL's due to dementia and limited mobility that indicated R91 required extensive assist of one staff with personal hygiene and dressing.	F 677	completed on 12/27/2021 no further issues identified. 3. A root cause analysis was conducted by the interdisciplinary team and it was identified that one Certified nursing assistant failed to monitor cleanliness of resident's clothing during routine care and following a meal. The Staff Developer/designee will provide an in-service education program for all certified nursing assistants to ensure that residents are in clothing that is clean and soil free. 4. The Unit Manager/designee will complete a random weekly audit (Attachment O) of 10 resident's clothing to assure compliance with the required care x 3 weeks. Once results demonstrate 100% compliance for 3 weeks, then monthly audits will be conducted x 3 months or until audit results are 100% x 3 consecutive months. This plan of correction will be monitored at the quarterly Quality Assurance meeting until substantial compliance has been met	

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F 677	Continued From page 30 12/1/21 1:37 PM - R91 was observed in the common area with long fingernails with dark brown debris underneath the nails. Also food debris (corn flakes cereal) was observed on R91's clothing. 12/2/21 10:02 AM - R91 was observed in the common area with long fingernails with dark debris underneath the nails and dried white droplets on R91's shirt. 12/2/21 2:18 PM - R91 was observed in the common area with long fingernails with dark debris underneath the nails and dried white droplets on the same shirt that R91 had on during the previous observation at 10:02 AM. During an interview on 12/2/21 at 2:39 PM, E14 (CNA) confirmed R91's soiled nails and clothing. E14 stated, "I just didn't notice." Findings were reviewed with E1 (NHA) and E2 (DON) during Exit Conference on 12/9/21, beginning at 1:00 PM.	F 677		
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 record review and interview it was	F 689	1.	1/7/22

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F 689	Continued From page 31 determined that the facility failed to ensure the environment remained free of accident hazards for one (R299) out of three (3) sampled residents reviewed for Accidents. R299 was assessed to require two staff person assistance for toileting. On 4/1/21, R299 fell out of the bed while receiving toileting care by one staff member. In addition, the facility failed to thoroughly investigate R299's fall on 4/2/21 by failing to identify that R299 required two staff persons when performing toileting. Findings include: Review of R299's clinical records revealed the following: 12/24/20 - R299 was admitted to the facility. 12/29/20 - The Admission MDS Assessment documented that R299 was independent with daily decision making and required extensive assistance of one staff for both bed mobility and toileting. In addition, R299 had a history of a fall prior to admission to the facility. 1/6/21 (Most recent review date 4/6/21) - A care plan for assistance with daily living documented that R299 required extensive assistance of one with bed mobility, toileting, and hygiene related to impaired mobility and weakness. Interventions included the assist of one person for turning and repositioning, assist with toileting as necessary and to provide assistance with bed mobility. 3/31/21 - The Quarterly MDS Assessment stated that R299 was independent with daily decision making and required extensive assistance of one person for bed mobility and extensive assistance of two staff persons for toileting.	F 689	1. The facility does not have the ability to retroactively address the unmet level of care assistance required with toileting for R299. 2. The facility has determined that all residents have the potential to be affected. 3. A root cause analysis was conducted by the interdisciplinary team and it was identified that one Certified nursing assistant failed to provide the required level of staff assistance with toileting. A full facility audit of all resident's level of assistance required with toileting will be complied and maintained at each nurse's station. The Staff Developer/designee will provide in-service education programs for all certified nursing assistants addressing regulations and facility expectations of staff to assure that all toileting care provided to residents match the ordered level of assistance for the resident. 4. The RNAC/designee will complete a random weekly audit (Attachment P) of 10 residents while receiving toileting care to assure compliance with staff providing the toileting care utilizing the ordered level of care for the resident x 3 weeks. Once results demonstrate 100% compliance for 3 weeks, then monthly audits will be conducted x 3 months or until audit results are 100% x 3 consecutive months. This plan of correction will be monitored at the quarterly Quality Assurance meeting until substantial compliance has been met	

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F 689	Continued From page 32 4/1/21 12:52 AM - A Nurse's Progress Note documented that at 11:10 PM on 4/1/21, R299 was found on the floor by E7 (CNA). R299 was assessed and complained of mild back pain. No additional complaints or injury was assessed and R299 was assisted back to bed. 4/2/21 1:43 AM - A Nurse's Progress Note documented that R299 had new complaints of pain in the rib cage area (both sides) and a chest x-ray was ordered. 4/2/21 11:57 AM - A Nurse's Progress Note documented that R299 continued with rib cage area pain and total body soreness. Bruising and swelling was noted to the left knee and right hand. Medication to treat the pain was administered for pain and body soreness with effective results. 4/3/21 10:48 AM - A Nurse's Progress Note documented that x-ray results of the right wrist and rib cage was negative for broken bones. 4/1/21 through 4/3/21 - The facility's investigative file, including the Post Fall Assesement were reviewed. The Witnessed Occurrences/Incident, dated 4/1/21, completed by E7 (CNA) stated that E7 was providing care and R299 was lying on her side with her back to E7. While E7 was reaching for ointment to put on R299's back side and as E7 turned her head, E7 heard R299 make a sound and as E7 looked, E7 saw R299 sliding off the bed. E7 grabbed across the bed, held onto R299 and lowered R299 to the floor. The facility's investigation documented that E7 was providing incontinence care at the ordered level of care with supplies at the bedside. The investigation lacked evidence that the facility identified that R299	F 689	2. 1. The facility does not have the ability to retroactively thoroughly investigate the fall occurrence on 4/1/2021 for R299. 2. The facility has determined that all residents have the potential to be affected. 3. A root cause analysis was conducted by the interdisciplinary team and it was identified that one nurse focused the investigation on bed mobility instead of toileting. The Quality Assurance Nurse/designee will provide in-service education programs for all Nursing Administration staff addressing regulations, and facility expectations of staff to assure that the investigation focuses on the correct ADL activity and required assistance needed. 4. The Quality Assurance Nurse/designee will complete a weekly audit (Attachment Q) of all incidents to assure compliance with thoroughly investigating incidents x 3 weeks. Once results demonstrate 100% compliance for 3 weeks, then monthly audits will be conducted x 3 months or until audit results are 100% x 3 consecutive months. This plan of correction will be monitored at the quarterly Quality Assurance meeting until substantial compliance has been met	

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F 689	Continued From page 33 required the assistance of two staff members for toileting, not one. The facility failed to ensure while toileting R299 that two staff were performing this activity. R299 rolled out of the bed onto the floor while one CNA (E7), turned away to obtain a tube of ointment. 12/9/21 10:32 AM - During an interview with E2 (DON), the above findings were reviewed. E2 responded, "I understand where you are coming from related to the toileting requirement for two staff persons as R299 was being toileted." Findings were reviewed with E1 (NHA) and E2 (DON) during the Exit Conference on 12/9/21, beginning at 1:00 PM.	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, interview, and record review, it was determined that for one (R71) out of two sampled residents reviewed for respiratory care services, the facility failed to provide appropriate respiratory care in accordance with professional standards of practice. The facility failed to ensure R71's (O2) oxygen tubing and	F 695	1. The facility does not have the ability to retroactively address the lack of physician's order to change R71's oxygen tubing and humidifier bottle weekly. 2. The facility has determined that all residents requiring oxygen have the	1/7/22

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F 695	Continued From page 34 humidifier bottle were changed weekly. Findings include: Review of R71's clinical records revealed the following: 9/9/21 - R71 was re-admitted to the facility with diagnoses including respiratory failure. 9/30/21 - R71 had a physician's order for oxygen. Random observations on 12/1/21 at 11:05 AM, 12/2/21 at 4:15 PM and 12/7/21 at 12:10 PM revealed R71's oxygen tubing and humidifier bottle was undated. 12/7/21 12:16 PM - In an interview, E13 (LPN) confirmed the surveyor's observation that R71's oxygen tubing and humidifier bottle were not dated. 12/8/21 1:00 PM - Review of R71's December 2021 Treatment Administration Record (TAR) revealed the facility lacked evidence of a physician's order to change oxygen tubing and humidifier bottle weekly. 12/8//21 12:10 PM - During interview, E2 (DON) confirmed that the facility lacked evidence that R71 had a physician's order to change oxygen tubing and humidifier bottle weekly. Findings were reviewed with E1 (NHA) and E2 (DON) during Exit Conference on 12/9/21 beginning at 1:00 PM.	F 695	potential to be affected. A full facility audit of all resident's utilizing oxygen was conducted to ensure a physician order to change oxygen tubing and humidifier weekly was present; no further issues identified. Another facility audit was completed to ensure that all oxygen tubing and humidifier bottles were labeled (dated & timed) & documented on the TAR – no issues identified. 3. The facility created an Oxygen utilization policy addressing changing and documenting 02 tubing and humidifiers (Attachment A-1). A root cause analysis was conducted by the interdisciplinary team and it was identified that the admitting nurse did not enter oxygen orders related to a lack of thoroughness. The Staff Developer/designee will provide in-service education programs for licensed nursing staff addressing facility Oxygen utilization policy, regulations and facility expectations of staff to assure that appropriate physicians orders are obtained for residents that require oxygen therapy, as well as changing, labeling (date & time) of 02 tubing and humidifier bottles, and documenting on TARs. 4. The Assistant Director of Nursing/designee will complete a weekly audit (Attachment R) of all residents receiving oxygen therapy, to assure appropriate physician orders are present x 3 weeks. Once results demonstrate 100% compliance for 3 weeks, then monthly audits will be conducted x 3 months or until audit results are 100% x 3	

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F 695	Continued From page 35	F 695	consecutive months. This plan of correction will be monitored at the quarterly Quality Assurance meeting until substantial compliance has been met.	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, it was determined that the facility failed to ensure that food was stored, prepared, and served in a sanitary manner. Findings include: The following was observed on 12/6/21 at approximately 10:04 AM during the kitchen tour: -The ice machine filter was covered in biofilm.	F 812	1. The facility does not have the ability to retroactively address the ice machine being covered with biofilm on 12/6/2021. 2. The facility has determined that all residents have the ability to be affected by this practice. 3. A root cause analysis was conducted by the interdisciplinary team and it was	1/7/22

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F 812	Continued From page 36 The finding was confirmed by the (Food Service Director) on 12/6/21 at approximately 10:45 AM. The finding was reviewed with E1 (NHA) and E2 (DON) during Exit Conference on 12/9/21, beginning at 1:00 PM.	F 812	identified that the ice machine filter was not routinely monitored. The Dietician/designee will provide an in-service education program for the Food service director to ensure that the ice machine filter is clean. The maintenance department will also receive education from the Staff Developer/designee to ensure that the ice machine filter is changed monthly and as needed. 4. The Food service director/designee will complete a daily audit (Attachment S) to ensure that the ice machine filter is clean x 3 weeks. Once results demonstrate 100% compliance for 3 weeks, then monthly audits will be conducted x 3 months or until audit results are 100% x 3 consecutive months. This plan of correction will be monitored at the quarterly Quality Assurance meeting until substantial compliance has been met.	
F 835 SS=F	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on survey investigative findings, review of facility job descriptions and interviews, it was determined that the facility failed to be administered in a manner that enabled it to use its resources effectively and efficiently during a	F 835	1. The facility does not have the ability to retroactively address the administration of the facility in a manner which utilizes all accessible resources to maintain appropriate infection control practices.	1/7/22

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F 835	Continued From page 37 COVID-19 outbreak where the facility failed to implement appropriate infection control practices, despite having access to current guidance from the Centers of Disease Control and Prevention (CDC), the State of Delaware's Division of Public Health (DPH) and the State Health Operations Center (SHOC), in addition to other resources. Findings include: Cross refer to F880 The facility's job descriptions were: - Administrator: The primary purpose of your job position is to direct the day-to-day functions in accordance with current federal, state, and local standards, guidelines, and regulations that govern long-term care facilities to assure that the highest degree of quality care can be provided to our residents at all times. - Infection Control Coordinator: The primary purpose of your job position is to plan, organize, develop, coordinate, and direct our infection control program and its activities in accordance with current federal, state, and local standards, guidelines, and regulations that govern such programs, and as may be directed by the Administrator and the Infection Control Committee to ensure that an effective infection control program is maintained at all times. 12/9/21 at approximately 10:30 AM - During an interview, E1 (NHA) stated that she keeps up with the changing COVID-19 guidance by: - participating in the SHOC conference calls; - receiving emails sent out from the Director of DHCQ; - receiving updates from E4 (ICP) during 9 AM daily meetings with the facility's management	F 835	2. The facility has determined that all residents have the ability to be affected by this practice. 3. A root cause analysis was conducted by the interdisciplinary team and it was identified that all Covid-19 protocol updates were not communicated effectively. The Infection Control Coordinator/designee will provide an in-service education program for the administrative team, including the Director of Nursing, Assistant Director of Nursing, and Staff Development, of the expectation to attend the SHOC conference calls, participate in the State's Long Term Care Association zoom calls, and review all CMC and CDC updates. 4. The Administrator will require a weekly written update (Attachment S1) of any new regulations and associated policy updates (if applicable) as a result of the SHOC conference calls, participate in the State's Long Term Care Association zoom calls, and review all CMC and CDC updates x 3 weeks. Once results demonstrate 100% compliance for 3 weeks, then monthly audits will be conducted x 3 months or until audit results are 100% x 3 consecutive months. This plan of correction will be monitored at the quarterly Quality Assurance meeting until substantial compliance has been met.	

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F 835	Continued From page 38 staff; - participating in the State's Long-Term Care Association; - retention of infection control consulting services for the past year; - monitoring CMS updates; and - through visits (3 to 4) from the State of Delaware's Incidence Response Team in the past year. 12/9/21 at approximately 10:40 AM - During an interview, E4 (ICP) stated that she keeps up with the changing COVID-19 guidance by: - participating in the SHOC conference calls; - receiving emails and participating in Zoom meetings with the State's Long Term Care Association to learn all the new guidance and to understand new verbiage; - receiving CMS updates; - receiving CDC emails and reviewing the CDC website and the Delaware Coronavirus website; and - participating in daily 9 AM meetings to discuss and review changes to make sure staff are educated on everything. Despite numerous Focused Infection Control (FIC) surveys (5/19/20, 10/13/20, 7/7/21 and 8/26/21) and participation by the facility in non-regulatory Incident Response Team visits for support and guidance with COVID-19 outbreaks, the facility failed to be administered in a manner utilizing all accessible resources to maintain appropriate infection control practices during a COVID-19 outbreak. 12/9/21 at 1 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (DON) and E4 (ICP).	F 835		

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F 868 SS=D	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i) §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; §483.75(g)(2) The quality assessment and assurance committee must: (i) Meet at least quarterly and as needed to identifying issues with respect to which quality assessment and assurance activities are necessary. This REQUIREMENT is not met as evidenced by: Based on interview and review of facility documentation as indicated, it was determined that the facility failed to ensure attendance of required members at the quarterly meetings. Findings include: The facility QAPI plan, last updated 8/1/21, indicated,"...Meeting at a minimum on a quarterly basis... E1 (NHA) administrator/owner/board member other leader". 12/3/21 - Review of the facility quarterly QA meeting sign in sheets revealed that during the 11/10/21 meeting all required members were not present. The facility administrator, owner or board member was not present. During an interview on 12/9/21 at 9:48 AM E1	F 868	1. The facility acknowledges that it failed to ensure attendance of all the required members at the 11/10/2021 quarterly Quality Assurance meeting and cannot retroactively correct this issue. 2. No residents were affected by this occurrence. 3. The QAPI plan was updated (Attachment T) on 12/28/2021 to reflect that in the absence of the administrator/board member, a representative can be appointed to represent their role for the Quality Assurance meeting, and upon return from the absence, the administrator/board member will review the minutes and	1/7/22

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F 868	Continued From page 40 (NHA) confirmed that she was not in attendance at the 11/10/21 quarterly QA meeting and stated that she did not appoint a designee for the meeting. E1 did state that she reviewed the QA in advance, and discussed the meeting minutes with E4(quality assurance administrator) during time of meeting and currently the infection control preventionist. Findings were reviewed with E1 (NHA) and E2 (DON) during Exit Conference on 12/9/21, beginning at 1:00 PM.	F 868	address any concerns. The Quality Assurance Nurse/designee will provide in-service education to all required members of the Quality Assurance team in regards to their required attendance at the quarterly meetings and appointing a representative in the event of their absence, as well as their expectation to review the minutes and addressing concerns upon return from absence. 4. The Quality Assurance Nurse/designee will complete an ongoing audit of all Quality Assurance meetings to ensure attendance requirements are met x 4 quarters until consecutive audit results of 100% are achieved for one year. This plan of correction will be monitored at the quarterly Quality Assurance meeting until substantial compliance has been met.	
F 880 SS=K	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 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,	F 880		12/30/21

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F 880	Continued From page 41 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 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	F 880		

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F 880	Continued From page 42 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, interviews, reviews of facility documentation and resources from national and state public health agencies as indicated, the facility failed to maintain a safe environment by not implementing the appropriate infection control practices as directed by the Centers for Disease Control and Prevention (CDC), the State of Delaware's Division of Public Health (DPH) and the State Health Operations Center (SHOC) during a COVID-19 outbreak in the facility. As a result of the facility's noncompliance, the likelihood of a serious adverse outcome of COVID-19 spreading to additional residents could have occurred if not corrected. The facility was notified of the Immediate Jeopardy (IJ) on Friday, 12/3/21, at 3 PM with an additional finding on Monday, 12/6/21 at 1:35 PM. The IJ was abated on Tuesday, 12/7/2021, at 2 PM. Findings include: Cross refer to F835 1. Earlier this year during the COVID-19 pandemic, the following national and state public health agencies, including the CDC, DPH and SHOC, provided infection control guidance to nursing home facilities as documented below:	F 880	1. 1 1. The facility does not have the ability to retroactively correct E22□s failure to utilize the appropriate PPE while caring for Covid positive residents on 12/3/2021. 2. The facility has determined that all residents have the potential to be affected by this practice. On 12/3/2021 at 1700, the facility placed Red Zone signage to the Covid-19 unit and supplied N95 masks for use on the Covid unit. Isolation gowns, gloves, goggles, and face shields were previously present on the Covid Unit. 3. A root cause analysis conducted by the interdisciplinary team, including the Infection Preventionist/Educator, Quality Assurance and Improvement Committee, and Governing Body, was completed on 12/3/2021 and it was identified that further staff education was required. The infection control policy related to Covid-19 was reviewed and the Nursing Administrative staff immediately began providing in-service education for all staff addressing policies and procedures,	

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F 880	Continued From page 43 4/9/21 (updated) - On the CDC website, the document entitled, "COVID-19 Strategies for Optimizing the Supply of N95 Respirators" stated, "Situational update as of May 2021: The supply and availability of NIOSH-approved respirators have increased significantly over the last several months. Healthcare facilities should not be using crisis capacity strategies at this time and should promptly resume conventional practices. Check the NIOSH Certified Equipment List to identify all NIOSH-approved respirators. Healthcare facilities should stop purchasing non-NIOSH approved respirators for use as respiratory protection and consider using any that have been stored for source control where respiratory protection is not needed ... Healthcare facilities should return to using only NIOSH-approved respirators where needed ... It is important that HCP (Healthcare Personnel) be trained on indications for use and the proper use of N95 respirators. The OSHA Respiratory Protection standard requires employers to provide respirator training to an employee prior to use in the workplace ... Proper use of respirators, including putting on and removing them, limitations on their use, and maintenance, is essential for effective use of respiratory protection. HCP should be thoroughly trained before they are fit tested to ensure they are comfortable donning (putting on) the respirator and know how to conduct a user seal check. HCP should be trained on the respirator they are expecting to use at work ... Personal Protective Equipment: Respiratory Protection ... Proper use of respiratory protection by HCP requires a comprehensive program (including medical clearance, training, and fit testing) that complies with OSHA's Respiratory Protection Standard and a high level of HCP involvement	F 880	regulations, and facility expectations of staff to ensure that all staff are utilizing the appropriate PPE while caring for Covid positive residents. 4. The Infection Control Nurse/designee will complete a daily audit (Attachment U) of all three shifts to ensure all staff are utilizing the appropriate PPE x 3 weeks. Once results demonstrate 100% compliance for 3 weeks, then monthly audits will be conducted x 3 months or until audit results are 100% x 3 consecutive months. This plan of correction will be monitored at the quarterly Quality Assurance meeting until substantial compliance has been met. 1. 2 1. The facility does not have the ability to retroactively correct the Covid-19 unit not being a separate, discrete unit, with designated staff to care for the Covid positive residents on 12/1/2021 through 12/3/2021 at 1700. 2. The facility has determined that all residents have the potential to be affected by this practice. On 12/3/2021 at 1700, the facility immediately designated staff to the Covid-19 unit and the Covid-19 unit was redesigned to include a separate entrance and exit, and an empty room to be utilized as the designated staff break area which included a bathroom. 3. A root cause analysis conducted by the interdisciplinary team including, the Infection Preventionist/Educator, Quality	

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F 880	Continued From page 44 and commitment. The program should also include provisions for the cleaning, disinfecting, inspection, repair, and storage of respirators used by HCP on the job according to manufacturer's instructions ...". (https://www.cdc.gov) 4/20/21 - According to the SHOC Call Minutes, the following information was documented and emailed to all healthcare facilities: "Core Principles of COVID-19 Infection Prevention: ... Appropriate staff use of Personal Protective Equipment (PPE); Effective cohorting of residents (e.g. separate areas dedicated to COVID-19 care) ...". The DHCQ Medical Director (S4) addressed the following on the conference call: " ... The CDC came up with this guidance because N95's are much more available ... the standard is used for both red & yellow zones. We want to make sure you all understand what the minimal standards are ... With new guidance coming in, the CDC is saying when you know someone is at a significant risk of COVID, staff workers should be utilizing N95 masks ... I encourage you to look up the CDC guidance ...". 5/28/21 (last update) - On the Delaware Coronavirus website, the DPH document entitled "Cohorting Plan for Long Term Care Facilities", stated, " ... The most effective way to prevent spread of COVID-19 in congregate settings is to create 'zones' of similarly dispositioned patients by cohorting them in physically designated areas ... Cohorting is most effective ... when there are dedicated staff and equipment for each cohort ... Red (COVID-19 Positive/Isolation) Zone ... Healthcare workers should wear full personal protective equipment (PPE) (gloves, gown, N-95 mask and eye protection) when taking care of these patients ... the priority is that the Red Zone	F 880	Assurance and Improvement Committee, and Governing Body, was completed on 12/3/2021 and it was identified that further staff education was required. The infection control policy related to Covid-19 was reviewed and updated to include Zoning & PPE usage (Attachment U) and the Nursing Administrative staff immediately began providing in-service education for all staff addressing policies and procedures, regulations, and facility expectations of staff to ensure that all staff are aware of and are correctly utilizing the appropriate Covid-19 Zones, including the separate, distinct Red Zone, as well as designated staff to that zone. Educated also included that the designated staff are not to go into any non- Covid areas of the facility, entering and exiting through the designated entrance only. 4. The Infection Control Nurse/designee will complete a daily audit (Attachment V) of all three shifts to ensure all staff are following the correct Zoning procedures, including the Red Zone x 3 weeks. Once results demonstrate 100% compliance for 3 weeks, then monthly audits will be conducted x 3 months or until audit results are 100% x 3 consecutive months. This plan of correction will be monitored at the quarterly Quality Assurance meeting until substantial compliance has been met. 1. 3 1. The facility does not have the ability to retroactively correct the Covid-19 unit not having a separate receptacle for soiled	

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F 880	Continued From page 45 have a separate breakroom for staff ...". (https://coronavirus.delaware.gov) Undated - According to the Delaware Coronavirus website, a DPH document entitled, "Staff PPE for Different Zones" outlined the required PPE in the Red Zone (COVID positive on Transmission Based Precautions): Gown, Gloves, Surgical Mask, Face shield/eye protection and N-95 Mask Required**** ... ***During an outbreak Green zones should also be in Gowns/gloves/mask unless unit is discrete, and staff are dedicated to the unit. ****Refer to CDC guidance: Strategies for Optimizing the Supply of N95 Respirators." Observations revealed the following: 12/1/21 from 10:30 AM to 11:20 AM - Observations of the three resident floors revealed that all staff were wearing face masks. Outside of the COVID-19 unit on the first floor, which was separated by a plastic barrier, a box of disposable KN95 face masks were observed sitting on top of the isolation cart for staff to use. 12/1/21 - The facility's COVID-19 line listing revealed that three residents (R2, R31 and R62) tested positive for COVID-19 and were in the COVID-19 unit, rooms 106, 107 and 108. 12/1/21 - The facility's staffing assignments on the 7 AM - 3 PM shift revealed that E23 (RN) and E20 (CNA) were assigned to provide direct care to both COVID-19 positive residents and COVID negative residents. 12/3/21 at 10 AM - An observation on the first floor in the hallway where the COVID-19 unit was located revealed E20 (CNA) entering the	F 880	linens within the Covid-19 unit on 12/3/2021. 2. The facility has determined that all residents have the potential to be affected by this practice. On 12/3/2021 at 1700, the facility immediately implemented a separate receptacle for soiled linens within the Covid-19 unit. 3. A root cause analysis conducted by the interdisciplinary team, including the Infection Preventionist/Educator, Quality Assurance and Improvement Committee, and Governing Body, was completed on 12/3/2021 and it was identified that further staff education was required. The infection control policy related to Covid-19 was reviewed and the Nursing Administrative staff immediately began providing in-service education for all staff addressing policies and procedures, regulations, and facility expectations of staff to ensure that all staff are aware of the handling of soiled linens within the Covid-19 unit (Red Zone). 4. The Infection Control Nurse/designee will complete a daily audit (Attachment V) of all three shifts to ensure all staff are following the correct Red Zone linen procedures x 3 weeks. Once results demonstrate 100% compliance for 3 weeks, then monthly audits will be conducted x 3 months or until audit results are 100% x 3 consecutive months. This plan of correction will be monitored at the quarterly Quality Assurance meeting until substantial compliance has been met.	

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F 880	Continued From page 46 COVID-19 unit through the zippered plastic barrier wearing only a surgical face mask. E10 (RNAC) was immediately informed of the observation as she was the closest staff person in the hallway at the time. At 10:05 AM, E1 (NHA) and E4 (ICP) were walking towards the COVID-19 unit and were notified of the observation. At 10:25 AM, E4 (ICP), E21 (Staff Educator) and the Surveyor (S1) observed E20 (CNA) exit from the COVID-19 unit through the plastic barrier wearing a surgical mask and carrying a clear plastic bag containing linen from the COVID-19 unit down the hallway to the opposite end to dispose of the bag of linen in the soiled utility room. The facility failed to ensure that staff were wearing appropriate PPE in the COVID-19 unit; that the COVID-19 unit was separate, distinct and discrete; and the COVID-19 unit had a separate receptacle for soiled linen located within the unit itself. 12/3/21 at 10:31 AM - During an interview in the presence of E4 (ICP) and E21 (Staff Educator), E20 (CNA) confirmed that she was assigned to provide direct care to both COVID-19 positive residents and COVID negative residents. When E20 was asked if she wore a N95 mask in the COVID-19 unit, E20 stated, "No, it was too heavy." E20 confirmed that she wore a surgical mask when she provided direct care to a COVID positive resident. E20 stated that she removed her PPE after leaving the resident's room, changed her surgical mask and hand sanitized. 12/3/21 at 12:25 PM - During discussion with the State Agency, it was determined that the facility was not following guidance from the CDC and DPH with respect to the COVID-19 outbreak. The DPH guidance for COVID-19 outbreaks located	F 880	1. 4 1. The facility does not have the ability to retroactively correct the issue that the facility staff were not trained and fit-tested for N95 masks. 2. The facility has determined that all residents have the potential to be affected by this practice. On 12/6/2021 at 1630 Kentmere ensured there was a Fit Tested nursing staff member on schedule throughout the 3-11 and 11-7 shift to care for the Covid-19 positive resident. A Fit Tester came into the facility on 12/6/2021 and Fit Tested the RN working the 3-11 shift, at approximately 1730, who also worked 11-7 on 12/6/2021. On 12/7/2021, National Fit Test Services was on site and fit tested 7 Kentmere employees. National Fit Test Services was also on site at Kentmere on 12/9/2021 at 11:00am through 5:00pm and 12/10/2021 at 6:00am through 2:00pm to Fit Test Kentmere employees; a total of 90 employees were fit tested. A Train the Trainer of Kentmere staff was completed on 12/27/2021, to ensure that any staff not Fit Tested by the National Fit test service, as well as future new hire staff, can be Fit Tested. Until all staff are Fit Tested, Kentmere will ensure that a staff member that is Fit Tested is on shift to care for any future Covid-19 positive resident. 3. A root cause analysis conducted by the interdisciplinary team, including the Infection Preventionist/Educator, Quality Assurance and Improvement Committee, and Governing Body, was completed on 12/3/2021 and it was identified that further	

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F 880	Continued From page 47 on the Delaware Coronavirus website stated that unless the COVID-19 unit was discrete and staff were dedicated to the unit, the facility's staff should also be in gowns, gloves and masks in the Green zones where non-COVID residents reside. [Face shield/eye protection was not required, but to strongly consider if the community positivity rates are in yellow or red.] The facility did not have a separate, distinct and discrete COVID-19 unit, which included and was not limited to, dedicated staff, a separate entrance/exit for staff with screening procedures for dedicated staff upon entrance, and a separate breakroom and bathroom for dedicated staff. The facility failed to have neither infection control practice in place during a COVID-19 outbreak from the first day of the survey on 12/1/21. 12/3/21 at 1:15 PM - During a follow-up interview by S2 and S3 (Surveyors), E20 (CNA) stated that she was assigned to the COVID-19 positive residents in rooms 106, 107 and 108. E20 was observed wearing a surgical mask as she was walking around the first floor nurse's station, two and a half hours after providing direct care to a COVID-19 positive resident while wearing a surgical mask, and not the required N95 face mask. According to E20's Time Card Report on 12/3/21, E20 worked the entire day shift from 6:59 AM to 3:31 PM. 12/3/21 at 1:20 PM - During an interview by S2 and S3 (Surveyors), E22 (AA) stated that she was assigned to provide activities to all of the residents on the first floor, including the COVID-19 positive residents in rooms 106, 107 and 108. E22 was observed wearing a KN95 mask during the interview. E22 stated that before entering the closed off COVID-19 area, she would	F 880	staff education was required. The infection control policy related to Covid-19 was reviewed and an N95 policy and procedure was developed. The Nursing Administrative staff immediately began providing in-service education for all staff addressing policies and procedures, regulations, and facility expectations of staff to ensure that all staff are fit tested and utilizing the appropriate N95 mask. 4. The Infection Control Nurse/designee will complete a daily audit (Attachment V) of all three shifts to ensure all staff that are caring for Covid-19 positive residents are Fit tested and utilizing the appropriate N95 mask x 3 weeks. Once results demonstrate 100% compliance for 3 weeks, then monthly audits will be conducted x 3 months or until audit results are 100% x 3 consecutive months. This plan of correction will be monitored at the quarterly Quality Assurance meeting until substantial compliance has been met. 2. 1. The facility does not have the ability to retroactively appropriately social distance R42, R69, and R301. 2. The facility has determined that all residents have the potential to be affected. 3. A root cause analysis conducted by the interdisciplinary team was completed on 12/1/2021 and it was identified that further staff education was required. The infection control policy related to Covid-19	

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F 880	Continued From page 48 apply gloves, a gown, a KN95 mask and eye protection. Before she leaves the closed off area, she would remove all PPE, sanitize her hands upon exit and don a new KN95 mask. 12/3/21 at 1:27 PM - During an interview by S2 and S3 (Surveyors), E13 (LPN) stated that she was assigned to residents from rooms 101 through 115, which included the COVID-19 positive residents in rooms 106, 107 and 108. E13 was observed wearing a KN95 mask during the interview. E13 stated that before entering the closed off COVID-19 area, she would apply gloves, a gown, a KN95 and eye protection. Before she leaves the closed off area, she would remove all PPE, sanitize her hands upon exit and don a new KN95 mask. 12/3/21 at 3:03 PM - The survey team met with E1 (NHA), E2 (DON) and E4 (ICP). The facility was notified of an Immediate Jeopardy due to lack of implementing appropriate infection control practices during a COVID-19 outbreak. 12/3/21 at 5:22 PM - The facility's IJ abatement plan included: "-At 4 PM, education sessions of staff were initiated and covered the PPE required in the Red Zone (COVID unit), the utilization of designated staff in the COVID-19 unit, including the use of a separate entrance/exit and a designated staff breakroom in the COVID unit, including a bathroom. The designated staff will be educated that they are not to go into any non-COVID areas of the facility, entering and exiting through the designated entrance only. -At 5 PM, the facility placed Red Zone signage to the COVID-19 unit; -At 5 PM, the facility immediately designated staff	F 880	was reviewed and the Staff Developer/designee has provided an in-service education program for all staff addressing policies and procedures, regulations, and facility expectations of staff to ensure that residents are safely distanced from one another □ minimum of 6 feet, at all times. 4. The Assistant Director of Nursing/designee will complete a daily audit (Attachment W) of all resident common areas and hallways to ensure adequate social distancing x 3 weeks and then monthly x 3 weeks. Once results demonstrate 100% compliance for 3 weeks, then monthly audits will be conducted x 3 months or until audit results are 100% x 3 consecutive months. This plan of correction will be monitored at the quarterly Quality Assurance meeting until substantial compliance has been met.	

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F 880	Continued From page 49 to the COVID-19 unit. The COVID-19 unit was redesigned to include a separate entrance and exit, an empty room to be utilized as the designated staff break area which includes bathroom; and -At 5 PM, the facility supplied N95 masks for use on the COVID-19 unit." 12/3/21 at 5:35 PM - S1 and S2 (Surveyors) with E2 (DON) observed the separate, distinct and discrete COVID-19 unit. E24 (LPN) was designated to provide all of the direct care to the COVID-19 positive residents. 12/6/21 at 8:57 AM - An observation through the window on the entrance/exit door to the COVID-19 unit revealed that E24 had her own personal respirator. 12/6/21 at 9:30 AM - During an interview, E1 (NHA) was asked to provide more information on E24's (LPN) personal face mask being worn in the COVID-19 unit. In response, E2 (DON) provided E24's personal face mask information: Advantage 200LS Respirator Facepiece #815448. 12/6/21 from 12:00 PM to 1:15 PM - Multiple interviews conducted with direct floor staff revealed: -E13 (LPN) was observed wearing an N95, however, it was not fitted as there was an opening below her chin. E13 confirmed that she had not been trained nor fit-tested for the N95. E13 stated that she was told to wear them in the COVID-19 unit. -E16 (LPN) stated that the facility provided KN95's and surgical blue masks. E16 confirmed that she had not been trained nor fit-tested for the	F 880		

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F 880	Continued From page 50 N95. -E28 (Housekeeping) stated that she has never been "fitted" for the N95. -E29 (CNA) stated that she received an in-service to wear a N95 around the COVID-19 positive residents. However, she was not aware of the fit-testing requirement. -E30 (CNA) was observed wearing an N95, however, she had not received any N95 training or been fit tested. -E31 (LPN) stated that he had not received any N95 training or been fit tested. -E32 (CNA) stated that she was not aware of the fit testing requirement for N95. -E24 (LPN) stated that she was fit tested with her personal mask, Advantage 200LS Respirator, at her other job about four months ago. She stated that she was requested to remove her personal mask and wear a facility-provided N95. E24 confirmed that she had not received any N95 training or been fit tested in the facility. 12/6/21 at 1:30 PM - During an interview, E4 (ICP) confirmed that the facility was following CDC guidance for infection control prevention. E4 also confirmed that the facility had not provided training and fit testing of N95's for the staff. 12/6/21 at 1:35 PM - During an interview, E1 (NHA) and E4 (ICP) were informed that an additional finding was added to the Immediate Jeopardy and the facility's abatement plan will need to address the lack of training and fit-testing of N95s for staff. 12/6/21 at 3:34 PM - The facility amended their Immediate Jeopardy Abatement Plan to include: " ... At 2 PM, the facility's Infection Control Consultant was contacted to discuss a plan to get	F 880		

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F 880	Continued From page 51 all staff trained and fit-tested on the appropriate type of N95 required to be worn when providing direct care to a COVID-19 positive resident ... will be sending the contact information of fit testing resources by the close of business on 12/6/2021. Upon receipt of the contact information, arrangement will be made for the Fit testing trainer to come onsite as soon as possible. All staff will be fit tested and educated within seven business days." 12/7/21 at 2 PM - The facility's revised Immediate Jeopardy Abatement Plan with documented evidence addressing the lack of training and fit-testing on the appropriate type of N95 required to be worn when providing direct care to COVID-19 positive residents included the following: " ... On 12/6/2021, at approximately 1400 (2 PM), ... (the facility's) Infection Control Consultant was contacted to discuss a plan to get all staff trained and fit tested ... (Company name) will be on site at Kentmere 12/7/2021 to begin to fit test some of Kentmere staff. (Company name) will also be on site at Kentmere on 12/9/2021 at 11:00am through 5:00pm and 12/10/2021 at 6:00am through 2:00pm to Fit Test Kentmere employees. They will also be Training the Trainer of Kentmere staff to ensure that any staff not Fit Tested by them and future new hire staff, can be Fit Tested. To correct the immediacy of the situation, on 12/6/2021 at 1630 (4:30 PM) Kentmere ensured there was a fit tested nursing staff member on schedule throughout the 3-11 and 11-7 shift to care for the COVID-19 positive resident. A Fit Tester, (name), came into the facility on 12/6/2021 and Fit Tested (E33, RN) at approximately 1730 (5:30 PM). (E33), RN worked the 3-11 and 11-7 shift on 12/7/2021. On	F 880		

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 12/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 52 12/7/2021, (company name) was on site and fit tested 7 Kentmere employees. The employees Fit Tested on 12/7/2021 include: E4 (ICP), E2 (DON), E3 (ADON), E13 (LPN), E15 (RN, UM), E10 (RNAC), E21 (Staff Educator). Until all staff are Fit Tested, Kentmere will ensure that a staff member that is Fit Tested is on shift to care for any future COVID-19 positive resident." 2. An observation on 12/1/21 at 1:18 PM, during a COVID-19 outbreak in the facility, revealed three (R42, R69 and R301) residents sitting close together (within 6 feet) in the second floor TV lounge. All three residents were not wearing face masks. R42 and R301 were talking to each other, while R69 was sleeping in between them. Finding was immediately confirmed with E19 (LPN). 12/9/21 at 10:48 AM - Finding was reviewed with E1 (NHA), E2 (DON) and E4 (ICP). The facility failed to ensure that source control, specifically maintaining physical distance, was followed as part of their infection prevention and control program. 12/9/21 at 1 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (DON) and E4 (ICP).	F 880		