STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085033	A. BUILDING _____ B. WING _____	03/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES - PIKE CREEK	5651 LIMESTONE ROAD WILMINGTON, DE 19808

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An Emergency Preparedness Survey was conducted by the State of Delaware's Division of Health Care Quality Long Term Care Residents Protection in accordance with 42 CFR 483.73. Survey Date: 3/1/18 During this Emergency Preparedness Survey, ManorCare Health Services - Pike Creek was not found in substantial compliance with the Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 177 certified beds. At the time of the Survey, the census was 164.	E 000		
E 035 SS=F	LTC and ICF/IID Sharing Plan with Patients CFR(s): 483.73(c)(8) [(c) The [LTC facility and ICF/IID] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives. This REQUIREMENT is not met as evidenced by: Based on review and interviews, it was determined that the facility did not have a method for sharing information from the emergency plan with residents and family members or representatives. Findings include:	E 035	The Statements made on this plan of correction are not an admission to and do not constitute an agreement with alleged deficiencies herein. To remain in compliance with all federal and state	4/25/18

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

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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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E 035	Continued From page 1 Review of the facility's emergency preparedness program revealed there was no method in place for sharing information the facility deemed appropriate about its emergency plan with residents and their families or representatives. During an interview on 2/27/18 at 4 PM, R139 stated she was not aware of any facility plans in the event of an emergency. During an interview on 2/29/18 at 2:15 PM, E4 (Staff Development Coordinator) confirmed that information sharing has not occurred. Findings were reviewed with E1 (NHA) and E2 (DON) during the Exit Conference on 3/1/18 at 5:15 PM.	E 035	regulations, the facility has taken or will take the actions set forth in this plan of correction. The following plan of correction constitutes the facility□s allegation of compliance. All alleged deficiencies have been or will be corrected by the date or dates indicated. E 035 It is the intent of the facility to develop and maintain an emergency preparedness communication plan that complies with the Federal State and local laws. A. No residents were identified. The resident council was made aware of the emergency preparedness program on 2/28/18. The Admissions Director or designee will send information regarding the emergency preparedness program to current residents□ ; and representatives. The Admissions packets were updated to include the information regarding the emergency preparedness program B. Current residents have the potential of being affected by this program C. The Administrator or designee will educate the Admission Director, and other Department Directors regarding providing residents, families and representatives of the emergency preparedness program The Admissions Director or designee will audit new admissions to evaluate that the residents/representative have acknowledge receipt of the information	

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E 035	Continued From page 2	E 035	regarding the emergency preparedness program D. Audits will be completed daily until consistently reaching 100% success over three consecutive evaluations then three times then weekly until reaching 100% success over three consecutive evaluations then monthly until reaching 100% Results of these audits will be forwarded to the Quality Assurance Committee for review and evaluate need for further action times one.	
F 000	INITIAL COMMENTS An unannounced annual and complaint survey was conducted at this facility from February 20, 2018 to March 1, 2018. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census the first day of the survey was 164. The survey sample size was 55. Abbreviations / definitions in this report are as follows: AO x 1 - Alert and Oriented x 1/oriented to self only; ADON- assistant director of nursing; Acuity - the determination of how much nursing care/time each resident requires - higher acuity residents need more care/time; Alzheimer's disease (AD) - the most common cause of dementia in older people. A dementia is a medical condition that disrupts the way the brain works. AD affects the parts of the brain that control thought, memory, and language; Ambulate - moving about; walking;	F 000		

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F 000	Continued From page 1 Blunt mechanism - physical trauma to a body part when the body stops suddenly and tissues/organs continue to move forward, i.e. falls or motor vehicle accidents; Bradycardia - slow heart rate; fewer than 60 times per minute; C2 - a vertebra (bone) located in the cervical spine, extending from the base of the skull to the bottom of the neck.C2 is also known as the axis and allows the head to rotate from side to side, bend forward and bend backwards. Cervical spine is comprised of seven vertebrae and is responsible for supporting and stabilizing the neck and head; C-collar - medical device used to support a person's neck. It is also used by emergency personnel for those who have had traumatic head or neck injuries; C-spine - cervical spine, which consists of the first 7 vertebrae at the top of the spine (the part of the spine that connects to the base of your skull). This part of the spinal column protects some very important major nerves, including the ones that enable a person to breathe; CLOF - current level of function; CNA - Certified Nurse's Aide; CT - imaging test that takes detailed pictures of the inside of the body; Cervical - neck; Clonidine - medication that lowers blood pressure by decreasing the levels of certain chemicals in your blood. This allows the blood vessels to relax and the heart to beat more slowly and easily; Coccyx - tailbone; Cognitive - thinking; Congestive Heart Failure (CHF) - heart unable to pump enough blood to meet the body's needs; Corroborate - confirm or give support to; Coumadin - Anticoagulant/blood thinner;	F 000		

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DLTCRP - Division of Long Term Care Residents Protection or known as the State Survey Agency;
DNH - do not hospitalize;
DNR/DNI - do not resuscitate/do not intubate;
DON - Director of Nursing;
Deceleration - the sudden stopping of movement, a frequent mechanism of motion injury. Common causes of deceleration injury are motor vehicle accidents and falls;
Distraction - pulling apart;
Diuretic - medicines that help reduce the amount of water/excess fluid in the body;
ED - emergency department;
EHR - electronic health record;
EMS-emergency medical services;
eMAR - electronic Medication Administration Record;
EMS - emergency medical services;
ER - emergency room;
eTAR - electronic Treatment Administration Record;
Ecchymosis - bluish discoloration of an area of skin or mucous membrane caused by the extravasation of blood into the subcutaneous tissues as a result of trauma to the underlying blood vessels;
Extensive Assistance - resident involved in activity, staff provide weight-bearing support;
Expressive aphasia - partial loss of the ability to produce language (spoken or written), although comprehension generally remains intact;
F - Fahrenheit;
Fx - fracture;
Facial symmetry - one specific measure of bodily asymmetry, i.e. have resident smile, lift eyebrows and stick their tongue out;
Fibromyalgia - disorder characterized by widespread musculoskeletal pain;
Full Code - a designation that means to intercede

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F 000	Continued From page 3 if a patient's heart stops beating or if the patient stops breathing; Glasgow Coma Scale (GCS) - objective method of evaluating a trauma patient's neurologic status; H&P - history and physical; HOB - head of bed; Hematoma - collection of blood as a result of trauma, such as a black eye; Hemiparesis - unilateral weakness of the entire left or right side of the body; Hemiplegia - half of body paralyzed; Hoyer lift - sling-type mechanical lift; Hyperlipidemia - high cholesterol/triglycerides (fat proteins) associated with increased risk for heart disease and stroke; Hyperextending - forcefully extend a limb or joint beyond its normal limits so as to cause an injury; Hypertension - high blood pressure; leading cause of stroke; Hypotension - low blood pressure; Immobilization - process of holding a joint or bone in place; Incoherent - unclear speech; Incontinence - inability of the body to control the evacuative functions of urination or defecation; Indwelling catheter - small, flexible tube that is inserted through the urethra and into the bladder, allowing urine to drain; Intervention - any treatment or approach based upon clinical judgement and knowledge that a nurse performs to enhance patient outcomes; Interventional Radiology (IR) - medical specialty which provides minimally invasive image-guided diagnosis and treatment of disease; Intracranial - within the skull; Intubate - placement of a flexible plastic tube into the trachea (windpipe) to maintain an open airway; Kiosk - computer that provides access to	F 000		

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information and allows staff to enter the care provided to the resident;
L - liters;
LPN - Licensed Practical Nurse;
Laceration - deep cut or tear in skin or flesh;
Lethargic - sleepy;
MDS - Minimum Data Set/standardized assessment forms used in nursing homes;
mg - milligrams;
mm - millimeters;
MD-medical doctor;
Multiple Sclerosis - nervous system disease that affects the brain and spinal cord;
n/o - new order;
NC - nasal cannula;
NHA - Nursing Home Administrator;
NN - Nurse's Notes;
NP - Nurse Practitioner;
Negative Air Pressure - Negative room pressure is an isolation technique used in hospitals and medical centers to prevent cross-contaminations from room to room. It includes a ventilation system that generates negative pressure to allow air to flow into the isolation room but not escape from the room, as air will naturally flow from areas with higher pressure to areas with lower pressure, thereby preventing contaminated air from escaping the room;
Neurogenic bladder - a person lacks bladder control due to a brain, spinal cord, or nerve condition;
Neurological - science of the nerves and the nervous system;
Neurosurgery - medical specialty concerned with the prevention, diagnosis, surgical treatment, and rehabilitation of disorders which affect any portion of the nervous system including the brain, spinal cord, peripheral nerves, and cerebrovascular system;

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Ombudsman - resident representative who investigates reported complaints and helps to achieve agreement between parties;
OR - operating room;
ORIF - open reduction internal fixation is an orthopedic surgical procedure which is utilized to treat severe fractures;
PDA - private duty aide;
PLOF - previous level of function;
POC - point of care;
POT - plan of treatment;
prn - as needed;
PT - Physical Therapist or Physical Therapy;
Palatable - pleasant to taste;
Parietal hematoma - collection of blood from trauma located in the brain tissue;
Peripheral Vascular Disease (PVD) - common circulatory problem in which narrowed arteries reduce blood flow to your limbs;
Phlebotomist - medical professional who draws blood from residents for various lab tests;
Pressure Ulcers (PUs) - sore area of skin that develops when the blood supply to it is cut off due to pressure;
Prognostic - advance indication, serving to predict the likely outcome;
Prone - lying flat, especially face downward;
Propel - drive, push, or cause to move in a particular direction, typically forward;
PT/INR - blood test usually done when you are taking a blood thinner (anticoagulant) medicine, such as Coumadin, to prevent blood clots. Clots can block blood vessels and possibly cause a heart attack or stroke. This test measures the effect of the anticoagulant;
Pulse Ox (POX) - measures blood oxygen saturation levels (desired range 92% or higher);
RN - Registered Nurse;
Range of motion (ROM) - extent to which a joint

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can be moved safely;
Receptive aphasia - individuals have difficulty understanding written and spoken language;
Resuscitate - revive (someone) from unconsciousness or apparent death;
S/P - status post, a Latin expression that means "condition after";
SDC - Staff Development Coordinator;
SOB - shortness of breath;
Seizure - abnormal electrical activity in the brain causing repetitive muscle jerking;
Semi-fowlers - position of a patient who is lying in bed on their back with the head of the bed at approximately 30 to 45 degrees;
Schizophrenia - mental disorder with false beliefs of being harmed;
Spinal Cord - delicate collection of nerves that runs down the back, carries electrical signals between your brain and the rest of the body and controls your reflexes, and it is protected by the vertebral column;
Subdural hematoma - collection of blood in the space between the outer layer and middle layers of the covering of the brain. It is most often a result of a blow to the head;
Subluxation - subluxation is an incomplete or partial dislocation of a joint;
Stage III (3) Pressure Ulcer - skin develops an open, sunken hole called a crater. There is damage to the tissue below the skin;
Stand-Up Lift - mechanical assistive device that allows residents to be transferred between a bed and a chair;
Subgaleal hematoma - bleeding between the skull's deepest layer of the scalp and the scalp's tough layer of dense fibrous tissue which covers the upper part of the cranium;
TSU - Transitional Surgical Unit;
Triage - process of determining the priority of

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F 000	Continued From page 7 patients' treatments based on the severity of their condition; Type II Odontoid Fracture - unstable break of C2 where the joint is a peg, which fits into a groove in C1. In Type II, the peg is broken at its base, which occurs when the cervical spine is hyperextended (bent severely forward), i.e. trauma from a fall; UM - Unit Manager; Vascular Dementia - disease process that causes problems with reasoning, planning, judgment, memory and other thought processes caused by brain damage from impaired blood flow to your brain; Vertebral Artery Dissection - major arteries located at the base of the neck that carry blood from the heart to the brain. A dissection can be caused by injury to the head or neck which a tear develops in the artery wall allowing blood to collect within the wall layers and may form a clot, which could lead to a stroke; Velocity - acceleration of a freely-falling object; Zyprexa - anti-psychotic medication used to manage psychosis.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's	F 550		4/25/18

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F 550	Continued From page 8 individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that for one (R20) out of 55 sampled residents, the facility failed to promote care in a manner and environment that maintained or enhanced his dignity and respect in full recognition of his individuality. Findings include: During a dining observation in the 2nd floor dining room on 2/27/18 at 12:42 PM, E10 (CNA) referred to R20 as a "feeder" when explaining to	F 550	It is the intent of the facility that each resident is treated with respect in a manner and in an environment that enhances his or her quality of life A. R20 was not negatively impacted and continues to receive assistance in a dignified manner B. The Unit Managers or designee	

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F 550	Continued From page 9 E11 (CNA) why R20 did not currently have a tray. When the surveyor went over to see which resident E10 was referring to, E10 told the surveyor "he is a feeder that is why he does not have a tray." The facility failed to promote care in a manner and environment that maintained or enhanced R20's dignity and respect in full recognition of his individuality when they referred to him as a "feeder".. During the Exit Conference on 3/1/18 at approximately 5:15 PM, findings were reviewed with E1 (NHA) and E2 (DON).	F 550	conducted an audit on 3/12/18 of current residents that receive assistance for feeding to evaluate process is being completed in a dignified manner C. The Staff Development nurse or designee will educate nursing staff regarding addressing residents in a dignified manner D. The Unit Managers or designee will audit current residents that receive assistance with feeding to evaluate the staff act, or interact with residents during meals to promote dignity. Audits will be completed daily until consistently reaching 100% success over three consecutive evaluations then three times then weekly until reaching 100% success over three consecutive evaluations then monthly until reaching 100% Results of these audits will be forwarded to the Quality Assurance Committee for review and evaluate need for further action times one.	
F 577 SS=C	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.	F 577		4/25/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085033	A. BUILDING _____ B. WING _____	03/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES - PIKE CREEK	5651 LIMESTONE ROAD WILMINGTON, DE 19808

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 577	Continued From page 10 §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. (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 interviews and observations, it was determined that the facility failed to post the results of the State survey in a readily accessible area. Findings include: During the Resident Council meeting on 2/21/18 at 11 AM, in response to the question, "Is the State inspection available without having to ask?" Residents who attended the meeting responded "no". On 2/23/18 at approximately 10:30 AM, it was observed that there was a sign in the second floor hallway directly across from the elevators that stated, "Facility survey results located in the front lobby." On 2/23/18 at approximately 11 AM, it was observed that there was a sign immediately inside the front door of the facility, on a bulletin board which stated, "Facility survey results	F 577	It is the intent of the facility to ensure that the residents have the right to 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. A. No residents were identified as being affected by this practice. B. Current residents have the potential of being affected by this practice. C. The Administrator and or designee will educate the receptionist regarding the placement of the survey results binder in a prominent and accessible place D. The Administrator or designee will audit location of binder to evaluate that it is in a prominent and accessible place.	

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F 577	Continued From page 11 available upon request." On 2/23/18 at approximately 11:05 AM, inspection of the front lobby revealed a white binder which contained the State survey results, located on a lower shelf of a cabinet on a wall across from the sign on the bulletin board. The facility failed to post the results of the State survey in a readily accessible area where individuals wishing to examine the survey results did not have to ask for them. Findings were reviewed with E1 (NHA) and E2 (DON) on 3/1/18 at approximately 1:30 PM.	F 577	Audits will be completed daily until consistently reaching 100% success over three consecutive evaluations then three times then weekly until reaching 100% success over three consecutive evaluations then monthly until reaching 100% Results of these audits will be forwarded to the Quality Assurance	
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the	F 578		4/25/18

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F 578	Continued From page 12 facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to update R56's electronic health record (EHR) to reflect her Do Not Resuscitate (DNR) status. Findings include: 2/21/18 at 10:05 AM - A review of the admission snapshot for R56's EHR revealed that she was a "Full Code" effective 12/14/16. 2/23/18 at 11 AM - A review of R56's EHR revealed a physician's order, dated 12/20/17, which stated, "DNR/DNI (do not intubate). Do not hospitalize. RN may pronounce. Comfort Care." 2/23/18 at 11:40 AM - A review of R56's paper chart revealed a red sheet with DNR and DNH in the front of the chart.	F 578	It is the intent of the facility to ensure that residents have the right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate and advanced directive. A. Resident # 56 code status was reviewed with the physician and documented accordingly in the electronic medical record. B. The Unit Managers or designee conducted an audit of current residents to evaluate documentation in the electronic medical record was accurate and consistant.	

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F 578	Continued From page 13 During an interview with E6 (UM) on 2/23/18 at 11:49 AM, it was confirmed that the admission snapshot was not updated when the 12/20/17 physician's order was entered into the EHR. Findings were reviewed with E1 (NHA) and E2 (DON) on 3/1/18 at approximately 1:30 PM. The facility failed to update R56's EHR to reflect her DNR status.	F 578	C. The Staff Development Nurse and/or designee will educate licensed nurses regarding the documentation of code status in the electronic medical record. D. The Unit Manager or designee will audit current residents to evaluate current documentation of code status in the electronic medical record. Audits will be completed daily until consistently reaching 100% success over three consecutive evaluations then three times then weekly until reaching 100% success over three consecutive evaluations then monthly until reaching 100% Results of these audits will be forwarded to the Quality Assurance Committee for review and evaluate need for further action times one.	
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in	F 623		4/25/18

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F 623	Continued From page 14 paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal	F 623		

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F 623	Continued From page 15 hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).	F 623		

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F 623	Continued From page 16 This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews, it was determined that for two (R137 and R469) out of 55 sampled residents, the facility failed to notify the residents and the residents' representatives in writing of facility discharges and the reasons for the discharges. Findings include: 1. Review of R137's clinical record revealed: R137 was admitted to the facility on 12/9/17 and was discharged to the hospital on 1/19/18 due to injury from a fall with a return date of 1/21/18. Review of R137's clinical record provided no evidence that R137 and R137's representative were notified in writing of the facility discharge. During an interview with E1 (NHA) on 2/28/18 at 4:40 PM, it was confirmed that the facility failed to notify R137 and R137's representative in writing of the facility discharge and the reason for the discharge. E1 stated that the facility did not know that they needed to inform the resident and representative in writing of a facility discharge. During the Exit Conference on 3/1/18 at approximately 5:15 PM, findings were reviewed with E1 and E2 (DON). 2. Review of R469's clinical record revealed: R469 was admitted to the facility in 1999. R469 was admitted to the hospital on 2/1/18 for a change in mental status; she was readmitted back to the facility on 2/15/18. Review of R469's clinical record provided no	F 623	It is the intent that the facility notifies the resident, and the resident□s representative of the transfer or discharge and the reason of the move in writing and in a language and manner that they understand and send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. A. R# 137 no longer resides in the facility.R#469□s family along with the long Term Care Ombudsman was provided specific written notification as to the reason of the acute care transfer on 3/28/18. B. The Social Service Director or designee will audit residents that were transferred out or discharged since 3/19/18 to evaluate specific reason for acute care transfer, in writing, to the resident, the resident□s representative and to the Long-Term Care Ombudsman. C. The Administrator and or designee will educate the Social Service Director regarding the need to notify, in writing the specific reason for transfer, to the resident , the resident□s representative and the Long-Term Care Ombudsman. D. The Social Service Director or designee will audit residents that were transferred or discharged to evaluate that residents, representatives and the Long Term Care Ombudsman have been provided written documentation of the	

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F 623	Continued From page 17 evidence that R469's representative was notified in writing of the facility discharge. R469 would not need a copy as she had a severe cognitive impairment (never/rarely made decisions). Although the facility provided an Ombudsman Discharge Notification, dated 2/8/18, that stated R469 was transferred to an acute care hospital on 2/1/18 for an "acute medical event", the notification lacked specificity as to the reason for transfer in clear, easily understood terms. E1 (NHA) was interviewed on 2/26/18 at 3:50 PM and findings were reviewed. E1 stated she did not know the facility was supposed to give the resident (if applicable) and resident representative written information with the reason for transfer/discharge. Findings were reviewed during the Exit Conference on 3/1/18 at 5:15 PM with E1 and E2 (DON).	F 623	specific reason for the acute care transfer or discharge. Audits will be completed daily until consistently reaching 100% success over three consecutive evaluations then three times then weekly until reaching 100% success over three consecutive evaluations then monthly until reaching 100%. Results of these audits will be forwarded to the Quality Assurance Committee for review and evaluate need for further action times one.	
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state	F 625		4/25/18

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F 625	Continued From page 18 plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews, it was determined that for two (R137 and R469) out of 55 sampled residents, the facility failed to provide the residents or the residents' representatives with a written notice that specified the duration of the bed-hold policy at the time of discharge to the hospital. Additionally, the facility failed to have a bed-hold policy, including reserve bed payment and the duration of the bed-hold policy. Findings include: 1. Review of R137's clinical record revealed: R137 was admitted to the facility on 12/9/17 and was discharged to the hospital on 1/19/18 due to injury from a fall with a return date of 1/21/18. Review of R4's clinical record provided no evidence that R137 or R137's representative were provided, at the time of discharge to the hospital, a written notice which specified the duration of the bed-hold policy.	F 625	It is the intent of the facility to provide the resident and resident representative in writing the bed hold policy when a resident is transferred to a hospital or therapeutic leave. A. R#137 no longer resides in the facility.R#469□s representative was provided written information of the bed hold policy on 3/28/18. B. Corrective action was taken to identify any other residents effected. The Business Office Manager and or designee will audit residents that were transferred to the hospital or out on therapeutic leave since 3/19/18 to evaluate that written information of the bed hold policy to the resident and representative was provided.Bedhold policy submitted with POC (emailed to DLTCRP) on 4/17/18.	

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F 625	Continued From page 19 During an interview with E1 (NHA) on 2/28/18 at 4:40 PM, it was confirmed that the facility failed to provide R137 or R137's representative with a written notice of the duration of the bed-hold policy on 1/19/18. E1 stated that the facility was unaware that a second bed-hold policy notice needed to be provided when a resident was discharged to the hospital. During the Exit Conference on 3/1/18 at approximately 5:15 PM, findings were reviewed with E1 and E2 (DON). 2. Review of R469's clinical record revealed: R469 was admitted to the facility in 1999. R469 was admitted to the hospital on 2/1/18 for a change in mental status; she was readmitted back to the facility on 2/15/18. Review of R469's clinical record provided no evidence that R469's representative was provided, at the time of discharge to the hospital, a written notice of the bed-hold policy, including reserve bed payment and the duration of the bed-hold policy. R469 would not need a copy as she had a severe cognitive impairment (never/rarely made decisions). E1 (NHA) was interviewed on 2/26/18 at 3:50 PM and findings were reviewed. When asked for a copy of the bed-hold policy, E1 gave the surveyor a Patient Information Handbook (given on admission to the facility) which had bed hold information in it. E1 stated she did not know the facility was supposed to give the resident (if applicable) and resident representative notice of the bed-hold policy when residents are	F 625	C. The Administrator or designee will educate the Business Office Manager regarding providing the resident and representative written information regarding the bed hold policy upon discharge or therapeutic leave. The nursing Home Administrator or designee will update the bedhold policy to be provided to new admissions at the time of the admission sign in. D. The Business Office Manager or designee will audit residents that are transferred out or out on therapeutic leave to evaluate that residents were provided written information regarding the bed hold policy. Audits will be completed daily until consistently reaching 100% success over three consecutive evaluations then three times then weekly until reaching 100% success over three consecutive evaluations then monthly until reaching 100%. Results of these audits will be forwarded to the Quality Assurance Committee for review and evaluate need for further action times one.	

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F 625	Continued From page 20 transferred to the hospital or taking therapeutic leave from the facility. During an interview on 2/27/18 at 10:42 AM, E1 confirmed the facility did not have a bed-hold policy. Findings were reviewed during the Exit Conference on 3/1/18 at 5:15 PM with E1 and E2 (DON).	F 625		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, interviews, review of facility documentation and medical references, it was determined that for 4 (R50, R79, R90, and R379) out of 55 sampled residents, the facility failed to provide services that met professional standards of quality. Findings include: 1. Review of R50's clinical record revealed the resident was admitted on 3/27/15 with diagnosis of Congestive Heart Failure (CHF). The quarterly MDS on 12/20/17 indicated a weight loss greater than or equal to 5% in the last month or greater than or equal to 10% in the last 6 months. A Progress Note on 12/28/17 indicated R50 was	F 658	It is the facilities intent to provide residents with services that meets professional services. A. Resident # 50 weights were reviewed on 2/28/18 by the Registered Dietician and determined that weights were not accurate and weight loss/gain was not considered significant . Resident # 79 point of care documentation regarding turning and repositioning was reviewed. Resident #90 point of care documentation for 12/2/17, 12/3/17 and 12/4/17 were reviewed	4/25/18

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MANORCARE HEALTH SERVICES - PIKE CREEK	5651 LIMESTONE ROAD WILMINGTON, DE 19808

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F 658	Continued From page 21 receiving a diuretic medication due to CHF, increasing the potential for weight fluctuation. Review of R50's weight record revealed the following weights and scales used: 1/4/18: 216.4 lbs mechanical lift scale 1/7/18: 216.4 lbs sit down scale 1/13/18: 164.5 lbs sit down scale 1/13/18: 164.5 lbs sit down scale 1/20/18: 164.5 lbs standup scale 1/27/18: 223.4 lbs sit down scale 2/3/18: 223.3 lbs sit down scale The Weight Measurement Guide used by the facility stated that the same scale as for previous weights be used unless otherwise directed. If there was a discrepancy in weights (5 lbs for residents over 100 lbs.), the resident was to be weighed again as soon as the discrepancy was noted. R50's weight was not taken again when the weight on 1/27/18 showed a 59.1 lb weight gain from the previous weight obtained 7 days earlier (1/20/18). During an interview on 2/28/18 at 3:30 PM, E4 (SDC) stated she did not know why 3 different scales (mechanical lift, sit down and standup scales) were used to weigh R50. The facility failed to use the same scale when weighing R50; failed to identify a 59.1 lb. weight gain discrepancy that occurred within 7 days; and failed to reweigh R50 when there is a 5 lb. discrepancy as per the facility's Weight Measurement Guide.	F 658	Resident # 379 no longer resides in the facility. B. The Unit Managers or designee audited current residents□ weights to identify weight loss or gain. Those residents with weight loses or gains were evaluate by the Registered Dietician for accuracy and assessments completed. Audit completed and corrective action taken. The Unit Managers audited current residents□ point of care documentation to evaluate current need of turning and repositioning.Audit completed and corrective action taken. The Unit Managers audited residents that have been discharged since 3/1/18 to evaluate that the residents were taken out of the system at the time of discharge and revealed no additional documentation. Audit completed and corrective action taken. The Unit Manager or designee audit current residents with suspected head or neck injury since 3/1/18 to evaluate that neurological assessment that were completed were within normal limits, any need for head and cervical trauma was assessed appropriately and that 911 was called in a timely manner if necessary.Audit completed and corrective action taken. C. The Staff Development Nurse or designee will educate licensed nurses	

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F 658	Continued From page 22 Findings were reviewed during the Exit Conference with E1 (NHA) and E2 (DON) on 3/1/18 at 5:15 PM. 2. The facility's POC Overview CNA - Quick Reference Guide, dated August 2016, stated, "What to document: All patient care you provide ...When to document: Every time you provide care/assistance to a patient. Touch a patient, touch a kiosk!" Review of R79's clinical record revealed: R79 was admitted to the facility on 7/26/16. 8/11/16 - R79 was care planned for at risk for alteration in skin integrity with an approach to be turned and repositioned every 2 hours. 1/11/17 - The quarterly MDS stated that R79 needed extensive assistance with bed mobility and required two person assistance. 3/7/17 - R79 was care planned for an open area to the coccyx. Interventions included that R79 was again to be turned and repositioned every 2 hours. Review of R79's documentation survey report from February 2017- February 2018 revealed that staff were not documenting every time they touched the resident per the facility's documentation reference guide. From February 2017- February 2018, there were no shifts where staff initialed every 2 hours that R79 was turned and repositioned. For the vast majority of the shifts, staff only documented turning the resident every 2 hours one time for the whole shift. In addition, staff often documented turning and	F 658	regarding Weight Measurement Guide. The Registered Dietician educated the identified weight team obtaining weights. System change initiated. High risk residents are now identified (all current residents and all new admissions) through analysis of Braden Scale results and presence or absence of pressure ulcers by the intersidisciplinary team at the daily IDT meeting.The Staff Development Nurse will educate certified nursing assistant regarding point of care documentation of turning and repositioning for current residents including standards of frequency and documentation at point of service. The Staff Development Nurse will educate certified nursing assistants regarding only documenting on current residents. The Staff Development Nurse will educate licensed nurses regarding completion of neurological assessment, reviewing abnormal findings, considering head and or cervical trauma, calling 911 immediately. D. The Unit Manager of designee will audit current resident weights to evaluate weight discrepancies. The Unit Manager or designee will audit current residents□ regarding presence of point of care documentation and timliness related to the time of service, to evaluate turning and repositioning, documentation and evaluate that point of care has not	

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F 658	Continued From page 23 repositioning R79 every 2 hours for the whole shift 1 to 8 hours prior to the end of their shift. Staff also at times did not document turning R79 at all for the whole shift. During an interview on 2/27/18 at 3:04 PM, findings were confirmed with E2 (DON). The facility failed to meet professional standards of quality as evidenced by staff not documenting turning and repositioning R79 as per the facilities documentation reference guide, which stated to document every time you provide patient care. During the Exit Conference on 3/1/18 at approximately 5:15 PM, findings were reviewed with E1 (NHA) and E2. 3. Review of R90's clinical record revealed: R90 was admitted to the facility on 11/30/17. 11/30/17 - R90 was care planned for at risk for alteration in skin integrity and a pressure ulcer to the coccyx with an approach that included to be turned and repositioned every 2 hours. R90 was discharged to the hospital on 12/2/17 at approximately 11:55 AM and was re-admitted on 12/12/17. Staff documented turning and repositioning R90 every 2 hours on the documentation survey report on 12/2/17 at 2:52 PM and 10:27 PM, on 12/3/17 at 2:41 AM, 1:49 PM, and 5:45 PM, and on 12/4/17 at 6:59 AM. Staff documented turning and repositioning R90 for 6 shifts after she was discharged to the hospital. The 12/19/17 admission MDS stated that R90 needed extensive assistance with bed mobility	F 658	been documented for residents that have been discharged. The Unit Manager will audit residents with suspected head or neck injury for current completion of and evaluation of neurological assessments, and calling 911 timely. Audits will be completed daily until consistently reaching 100% success over three consecutive evaluations then three times then weekly until reaching 100% success over three consecutive evaluations then monthly until reaching 100%. Results of these audits will be forwarded to the Quality Assurance Committee for review and evaluate need for further action times one.	

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F 658	Continued From page 24 and required two person assistance. Review of R90's documentation survey report from December 2017- February 2018 revealed that staff were not documenting every time they touched the resident as per the facility's documentation reference guide. From December 2017- February 2018, there were no shifts where staff initialed every 2 hours that R90 was turned and repositioned. For the vast majority of the shifts, staff only documented turning the resident every 2 hours one time for the whole shift. In addition, staff often documented turning and repositioning R90 every 2 hours for the whole shift 1 to 8 hours prior to the end of their shift. During an interview on 2/27/18 at 3:04 PM, findings were confirmed with E2 (DON). The facility failed to meet professional standards of quality as evidenced by staff not documenting turning and repositioning R90 as per the facilities documentation reference guide, which stated to document every time you provide patient care and when staff documented turning and repositioning the resident when she was hospitalized. During the Exit Conference on 3/1/18 at approximately 5:15 PM, findings were reviewed with E1 (NHA) and E2. 4. Cross refer to F684, example 1 Mosby's nursing book entitled Medical-Surgical Nursing: Assessment and Management of Clinical Problems 6th Edition, dated 2004, stated, "...Spinal Cord Trauma...Causes of spinal cord injury include...falls...After stabilization at the accident scene, the person is transferred to a	F 658		

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F 658	Continued From page 25 medical facility...Fractures can occur as a result of...blunt trauma...All patients with facial injuries should be treated as though they have a cervical injury until proven otherwise by examination and imaging studies...". Mosby's nursing book entitled Priorities in Critical Care Nursing 5th edition, dated 2008, stated, "...Trauma...Blunt trauma is seen most often with...falls. Injuries occur because of the forces sustained during a rapid change in velocity (decleration)...The goal of prehospital care is immediate stabilization and transportation. This is achieved through...immobilization of the patient, and immediate transport...to the closest appropriate medical facility...Nursing management of the patient with traumatic injuries begins the moment a call for help is received...Assessment...The neurological assessment is the most important tool for evaluating the patient..., because it can indicate severity of injury, provide prognostic information, and dictate the speed with which further evaluation and treatment must proceed...". Review of R379's clinical record and facility documents revealed the following: 6/21/17 - The quarterly MDS assessment stated that R379 had short and long term memory problems and was 5 feet 1 inch tall and weighed 167 pounds. 8/14/17 at 7:30 PM - R379 fell from sitting on the edge of her elevated bed and hit the tiled floor with the left side of her face. The facility failed to consider the potential of head and/or cervical trauma based on the blunt mechanism of R379's fall, the assessment observations of swelling and	F 658		

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F 658	Continued From page 26 hematoma on the left side of her face, an abnormal and incomplete neurological assessment, abnormal vital signs, and incoherent sentences after the fall. R379 was transferred from the floor back to her bed using a sheet and 4 staff to lift her current weight of 162 pounds. 2/26/18 at 5:30 PM - During an interview, E28 (CNA) stated that after the fall, 4 staff placed R379 on a sheet and transferred her to the bed. E28 stated that the hoyer lift was in the Medbridge Unit. 2/26/18 at 6:03 PM - During an interview, E29 (CNA) stated that E28, E22 (RN), E30 (CNA) and E29 used a sheet to transfer R379 from the floor to the bed. The interview took place in R379's double occupancy room so E29 could show the surveyor exactly where R379 landed on the floor. This surveyor observed that the residents' beds could be unlocked and moved easily. In addition, this surveyor observed that bed side tables could be moved easily. 2/28/18 at 1:11 PM - During a telephone interview, E22 (RN) confirmed that E28, E29, E30 and E22 used a sheet to transfer R379 from the floor to the bed. E22 stated that once R379 was off the floor, she felt she could properly look at R379. When asked if transferring a resident by sheet was normal practice at the facility, E22 said no. E22 said because of R379's position, they could not get a lift to her as they could not get it between the dresser and the bed. When asked about immobilizing R379 after the fall, E22 stated that R379 said she was okay. E22 had conflicting information when she changed her story and said that she did not notice the hematoma until she got her in bed. E22 said that if there was obvious	F 658		

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injury they usually let the paramedics move them. When asked if it was the facility's practice to move a resident back to bed when they have fallen and landed on their face, E22 said yes if done safely. When asked even if the resident was cognitively impaired, E22 said she can tell you if she was in pain. When asked if it ever entered E22's mind that R379 could have injured her head and neck before they moved her, E22 said she would not move anyone if there was suspected injury. E22 stated that she depended on being told by the CNAs as to what happened and knew she did not fall from the lift. E22 said she didn't bother to look at the height of the bed and that she was more interested in the resident.

8/14/17 at 9:26 PM - EMS arrived at the facility and stated, "...After a rapid assessment and noticing that the patient fell and landed on her head, a C-collar was put on to protect from further spinal injury if there is any. It was also noticed that the patient had a laceration to the left eyebrow and forehead with swelling and controlled bleeding from the left eye...When being loaded into bed via a standing lift and assisted by 2 facility staff members, the patient fell and landed directly on her head without using her arms to brace her fall...".

8/17/17 at 11:40 PM - The hospital's Discharge Summary after the 8/14/17 fall stated that R379 sustained a Type II Odontoid Fracture and a right Vertebral Artery Dissection. R379 underwent surgery for an odontoid screw placement for stabilization of C2.

3/1/18 at 5:50 PM - Findings were reviewed during the Exit Conference with E1 (NHA) and E2 (DON). The facility failed to provide care and

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F 658	Continued From page 28 services that met professional standards of quality when the facility failed to consider head and/or neck injury due to the blunt mechanism of her fall, her facial injuries and abnormal and incomplete assessment findings. Instead, the facility moved R379 using a sheet and 4 staff after she fell on her face from her elevated bed to the tiled floor on 8/14/17 and waited approx. 2 hours to call 911.	F 658		
F 679 SS=E	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and interviews, it was determined that the facility failed to provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community for three (R13, R22 and R145) out of 55 sampled residents. Findings include:	F 679	It is the intent of the facility to provide activities that interest/needs of each resident. A. Resident #13 has been re-evaluated and reviewed; care plans updated to better meet their current leisure interest and social needs to create an individual activity plan of care The monthly calendar has been reviewed and updated to include evening activities and non-religious activities on Sundays.	4/25/18

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F 679	Continued From page 29 1. Review of R13's clinical record revealed the following: R13 was admitted to the facility on 8/19/16 with diagnoses that included Alzheimer's disease, anxiety and depression. R13 resided on the facility's Arcadia unit (locked dementia unit). 9/1/16 - The facility developed a care plan, last revised 11/29/17, for "sometimes participates in activities such as arts/crafts, music/hymns, and watching movies...". The goal for this care plan stated, "will participate, actively or passively, in activities that promote socialization with peers consistent with patient likes and interests/participate in independent leisure such as hymn sing, hymns with Lucy, musical activities/instruments, movie matinees, arts and crafts, gardening, and visiting with her family." Interventions included to encourage participation in group activities of interest; offer redirection/diversion as needed; provide supplies/materials for leisure activities as needed/requested; respect choice in regard to limited/no activity participation. 8/23/17 - The annual MDS assessment stated R13 had short and long term memory problems, was moderately impaired (decisions poor; cues/supervision required) for daily decision making skills, and required extensive assist of one staff for locomotion on and off the unit. The MDS assessment stated that Section F, listing R13's activity preferences, was completed based on interview with R13's family. The MDS listed the following activity preferences and their level of importance for R13: - Very important - listening to music you like; to be	F 679	B. The Activity Director or designee will audit current residents assessments were evaluated for current preferences and interest to determine best programming for these residnets. C. The activity schedule was adjusted to offer evening activities starting at 7pm 2 times weekly and the offering of non-religious activities every Sunday. The Activity Director or designee will re-educate Activity staff regarding the offering of programs based on residents preferences and interest. The Administrator or designee will educate the Activity Director regarding the monthly activity calendar to reflect evening activities and additional activities on Sundays , other that religious activities. D. The Activity Director or designee will conduct an audit of current residents□ programs facility wide to ensure residents are provided the opportunity to be involved in activities of interest and preference. Also, the Nursing Home Administrator or designee will audit the monthly activity calendar to ensure that evening activities are offered as well as non religious activities are offered on Sundays. Audits will be completed daily until consistently reaching 100% success over three consecutive evaluations then three times then weekly until reaching 100% success over three consecutive	

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F 679	Continued From page 30 around animals such as pets; to go outside to get fresh air when the weather is good; - Somewhat important - to have books, newspapers and magazines to read; to do things with groups of people; to do favorite activities; - Not very important - to keep up with news; to participate in religious services or practices. 8/24/17 - The annual Recreation/Activity Evaluation listed the following as R13's current interests: animals/pets (dogs); children/intergenerational (family); exercise/physical activities (enjoys walking); older movies; classical music; outdoors to get fresh air; magazines/National Geographic. The evaluation also listed activities in which R13 had no interest in including: arts and crafts; cards/games; and religious involvement. 10/18/17 - A Recreational Services note stated, "...can be difficult to engage in activities...prefers to often get out of chair and walk around the unit. During lounge activities staff encourage her participation in activities of potential interests such as arts and crafts and music programs...often a passive participant...". 11/29/17 - A quarterly Recreational Services note stated that R13 continues to reside on the Arcadia unit and can be difficult to engage in activities, but will at times participate in some physical games such as balloon toss or a craft with much encouragement. The note also stated that R13's family visited almost daily and take the resident to the lobby or outdoors during nice weather, and that activity staff will continue to encourage participation in activities of potential interest.	F 679	evaluations then monthly until reaching 100% Results of these audits will be forwarded to the Quality Assurance Committee for review and evaluate need for further action times one.	

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F 679	Continued From page 31 Review of R13's Daily Recreation/Activity Participation Documentation from 12/1/17 through 2/24/18 (a total of 86 days) revealed the following: - Arts and crafts - Documented resident was a passive participant on 16 days and refused participation on three (3) days. During the Recreation/Activity Evaluation, arts and crafts was an activity that was identified as R13 having no interest in; - Cards/Games - Documented resident was a passive participant on 11 days and refused participation on two (2) days. During the Recreation/Activity Evaluation, cards and games was an activity that was identified as R13 having no interest in; - Movies - Documented resident was a passive participant on 12/1/17, 1/5/18, 1/12/18, 1/19/18, and was an active participant on 2/16/18 and refused on 2/9/18; - Music/singing - Documented resident was a passive participant on 24 days and an active participant on one (1) occasion. Review of the Arcadia activity calendars from 12/17 through 2/24/18 revealed that the only activities involving music were "Hymn Sing" every Sunday and "Hymns with Lucy" every Monday. There was no evidence that R13 was provided with any classical music as per her current interests. - Reading/writing - Documented resident was a passive participant on 6 days; - Spiritual/Religious Activities - Documented resident was a passive participant on nine (9) days. During the Recreation/Activity Evaluation, religious involvement was an activity that was identified as R13 having no interest in. There was no evidence there were any pet visits in the facility and no evidence that R13 was ever provided the option of listening to classical music	F 679		

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F 679	Continued From page 32	F 679		

or reading or looking at magazines such as National Geographic.

The following observations were made of R13:

2/20/18 at 4:20 PM - R13 was seated in a wheelchair at a table in the lounge, leaning forward. The TV was playing but R13 was not engaged in the program. R13 had removed her non skid slipper socks which were lying on the table. There were 13 other residents in the lounge, none of which were watching the TV program and there was no other activity occurring. E19 (Activity Assistant) was present in the room working on charting.

2/22/18 at 10:25 AM - R13 was seated in a wheelchair at a table in the lounge. The TV was playing but R13 was not watching. There was no other activity occurring. E7 (Arcadia UM), who was in the room, stated "our activity aide is running late, they are getting me the keys so we can get started."

2/22/18 at 10:46 AM - R13 was observed standing up from her wheelchair assisted by E8 (Activity Director) to play ring toss. It was observed at this time that a private duty aide (PDA) for another resident was mainly conducting the ring toss activity. 11:00 AM - E19 was observed arriving on the unit.

2/22/18 at 11:20 AM - R13 observed seated in wheelchair with her head down. E19 continued with the ring toss activity.

2/22/18 at 2:10 PM - Observed there was no activity occurring in the Arcadia unit lounge. E19 was observed in the room looking in the closet.

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F 679	Continued From page 33 2/22/18 at 2:35 PM - R13 was observed seated in a wheelchair at a table with four (4) other residents. R13 had a container with clear liquid labeled Elmer's glue, a stack of wooden hearts and a container of glitter in front of her. There was no one attempting to engage R13 in the activity. E19 was seated at one end of the table interacting with 3 other residents. There were no other staff present in the room. A second table seated five (5) other residents with various items, such as artificial flowers and puzzles pieces, but there was no one engaging them in any activity. A third table had three (3) residents seated, who were not engaged in any activity. 2/22/18 at 3:18 PM - E19 remained at the end of the table with the same three (3) residents working on an arts and crafts activity. Twelve (12) other residents, including R13, are in the room not engaged in any activity. 2/23/18 at 10:20 AM - R13 was observed being wheeled around in the facility's main corridor by a visitor. 2/23/18 at 10:34 AM - R13 was observed seated at a table in the Arcadia lounge. Snacks, beverages and supplements were being passed to the residents. E8 and E19 were in the room, however there was no other activity occurring. 2/23/18 at 10:50 AM - R13 was observed participating briefly in beach ball toss. 2/27/18 at 10:32 AM - The Arcadia lounge was observed with R13 and 16 other residents present. E20 (Activity Assistant) was present and arranging residents in a circle. Snacks and	F 679		

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F 679	Continued From page 34 beverages were being passed to residents. R13 was observed in the circle along with 15 other residents. E20 was observed going around the circle from resident to resident attempting to engage them in completing exercises. R13 was observed trying to stand from her wheelchair and being instructed to sit by E20. E20 then bypassed R13 when it was her turn to be engaged in attempting the exercises. There was a total of 21 residents in the lounge at this time, 16 of which were positioned in the circle with the rest seated at tables not engaged in any activity. 2/27/18 at 11:07 AM - Observation revealed that R13 and 15 other residents remained in the circle, with 5 others at tables. The residents in the circle were playing balloon toss, while the others at the tables were not engaged in any activity. E20 was playing balloon toss with residents on one side of the circle causing her to have her back to the rest of the group. Another resident alerted E20 that R13 was standing up by clapping her hands. E20 directed R13 to sit down. E7 (UM) came in to the lounge at this time and asked R13 if she'd like to go for a walk while reapplying a non skid slipper sock that R13 had removed. R13 declined and E7 left the room. When E20 came around the circle to R13, she did not attempt to engage the resident in playing with the balloon. E18 (Corporate Nurse) came into the room and began playing balloon toss with residents. E18 attempted to engage R13, but she would not participate. E20 then proceeded to take out a bean bag toss game, which she propped up against a chair which proceeded to fall down. When E20 went to find something to hold the game in place, the PDA (assigned to another resident) held the game up and began to engage residents in the game. 11:12 AM - R13 was	F 679		

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F 679	Continued From page 35 observed attempting to stand and E18 began to talk with her. The PDA continued going around the circle with the bean bag game. At 11:20 AM, R13 was removed from the room by E18 due to restlessness. The facility failed to provide for R13, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. 3/1/18 approximately 9:30 AM - During an interview with E8 (Activity Director), findings were reviewed regarding the lack of an ongoing activity program for R13, which was based on her comprehensive assessment and activity preferences (such as access to classical music, magazines National Geographic). E8 stated that R13's family comes in and reads with her and takes her to the cafe. When asked, E8 stated that activities usually go until 4:30 or 5:00 PM. Findings were reviewed with E2 (DON) on 3/1/18 at 12:15 PM. E2 stated that she believed that the facility was participating in the State's music and memory program and that it likely was provided in the evenings. E2 stated that she would check with E8. There was no further information provided to the survey team. 2. During an interview on 2/21/18 at 9:16 AM, when asked if the activities were provided as often as the resident would like, including	F 679		

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F 679	Continued From page 36 weekends and evenings? R22 responded that there were "no activities on weekend evenings." Review of the facilities September 2017 - February 2018 activities calendar revealed that the last activity of the day began between 2 PM - 3:30 PM and the only day of the week there were any evening activities was on Thursdays at 7 PM. During an interview on 2/28/18 at 10 AM, findings were reviewed and confirmed with E8 (Activities Director). E8 stated the facility does not have evening activities other than Thursdays due to staffing issues and that a new employee just started that stays till 6, so they will start having some later activities. During the Exit Conference on 3/1/18 at approximately 5:15 PM, findings were reviewed with E1 (NHA) and E2 (DON). 3. During an interview on 2/20/18 at 9:47 AM, when asked if the activities were provided as often as the resident would like, including weekends and evenings? R145 responded that there were "no activities on Sundays except religious services." Review of the facilities September 2017 - February 2018 activities calendar revealed that only 3 Sundays, 12/31/17, 1/31/18, and 2/4/18, had non-religious activities. During an interview on 2/27/18 at 4:10 PM, findings were reviewed and confirmed with E8 (Activities Director). E8 stated there was only one activity staff member in the building on weekends, but now they recently hired someone and there will be two. E8 also stated the reason there was	F 679		

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F 679	Continued From page 37 only religious activities on Sundays was because the facility had volunteers for church activities on weekends. During the Exit Conference on 3/1/18 at approximately 5:15 PM, findings were reviewed with E1 (NHA) and E2 (DON).	F 679		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interviews and reviews of the residents' clinical records, facility documentation, hospital records and nursing standards of practice, it was determined that for two (R379 and R88) out of 55 sampled residents, the facility failed to ensure that the residents received treatment and care in accordance with professional standards of practice and the comprehensive person-centered care plan. For R379, the facility failed to perform complete neurological assessments of R379 after her 8/14/17 fall; failed to identify abnormal neurological assessment findings; failed to consider the potential of head and/or cervical trauma based on the blunt mechanism of R379's fall, the assessment observations of R379's laceration to the left eyebrow and forehead,	F 684	It is the intent of the facility to ensure that residents receive treatment and care in accordance with professional standards of practice. A. R#379 no longer resides in the facility.R#88 no longer resides in the facility B. The Unit Manager or designee audit current residents with any suspected head or neck injury since 3/1/18 to evaluate that neurological assessment were within normal limits, any need for head and cervical trauma was assessed appropriately and that 911 was called in a	4/25/18

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F 684	Continued From page 38 swelling and hematoma on the left side of her face, incoherent sentences after the fall, and unstable vital signs; and failed to immediately call 911 to transfer her to the Emergency Room (ER) for evaluation and treatment after a physician's order was received at 8:30 PM, and instead waited for an additional 47 minutes to call 911 at 9:17 PM, resulting in a delay in treatment and care. R379 was received and assessed as a Trauma Code in the ER, underwent surgery for placement of a screw for her Type II Odontoid Fracture and was diagnosed with a Vertebral Artery Dissection. In addition, the facility failed to monitor R379's blood pressure and heart rate prior to administering her two anti-hypertensive medications upon readmission to the facility on 8/17/17. The facility failed to follow a physician's order to monitor R379's pulse ox and titrate her oxygen to maintain her oxygen level greater than 92% during the evening shift of 12/6/17. For R88, the facility failed to obtain a physician's order to change her indwelling catheter. Findings include: Mosby's nursing book entitled Medical-Surgical Nursing: Assessment and Management of Clinical Problems 6th Edition, dated 2004, stated, "...Spinal Cord Trauma...Causes of spinal cord injury include...falls...After stabilization at the accident scene, the person is transferred to a medical facility...Fractures can occur as a result of...blunt trauma...All patients with facial injuries should be treated as though they have a cervical injury until proven otherwise by examination and imaging studies...". Mosby's nursing book entitled Priorities in Critical Care Nursing 5th edition, dated 2008, stated, "...Trauma...Blunt trauma is seen most often	F 684	timely manner if necessary. The Unit Manger or designee will audit current residents receiving anti-hypertensives to evaluate blood pressure and heart rate prior to administering per physician order. The Unit Manager or designee will audit current residents receiving oxygen to evaluate the physician order and reassessment after intervention is being carried out, and to include how many liters of oxygen are applied. The Unit Manager or designee will current residents with an indwelling catheter to evaluate physician orders for change if necessary. C. The Staff Development Nurse will educate licensed nurses on our neurological evaluation policy and completion of neurological assessment form which includes how to recognize abnormalities, reviewing abnormal findings, considering head and or cervical trauma,and calling 911 immediately.Policy and form emailed to DLTCRP to include with POC 4/17/18. The Staff Development Nurse will educate licensed nurses regarding oxygen therapy and reassessments after respiratory interventions, and following blood pressure and heart rate parameters as prescribed by a physician when	

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F 684	Continued From page 39 with...falls. Injuries occur because of the forces sustained during a rapid change in velocity (decleration)...The goal of prehospital care is immediate stabilization and transportation. This is achieved through...immobilization of the patient, and immediate transport...to the closest appropriate medical facility. Personnel providing prehospital care should also communicate information needed for triage at the hospital. Nursing management of the patient with traumatic injuries begins the moment a call for help is received...Assessment...The neurological assessment is the most important tool for evaluating the patient..., because it can indicate severity of injury, provide prognostic information, and dictate the speed with which further evaluation and treatment must proceed...". The facility's policy entitled Mechanical Lift, last revised 1/2014, stated the "Purpose: To move immobile or obese patients for whom manual transfer poses potential for staff or patient injury...Note: Although one person can operate most models of mechanical lifts, it's advisable to have two staff members present to stabilize and support the patient...Procedure: ...6. Ask another caregiver to assist with positioning by standing on opposite side of the bed and having patient roll toward second caregiver, away from lift side...Note: Patient may be lifted from bed, chair or floor using similar steps with a mechanical lift...". The facility's policy entitled Neurological: Neurological Evaluation, stated the "Purpose: ...used to establish a baseline neurological status upon which subsequent evaluations may be compared and changes in neurological status may be determined...Procedure: 1. Initiate and	F 684	administering an anti-hypertensive. The Staff Development Nurse or designee will educate licensed nurses regarding the need of a physician□s order to change a indwelling catheter. D. The Unit Manager will audit residents with suspected head or neck injury to evaluate current completion of and evaluation of neurological assessments, calling 911, timely. The Unit Manager will audit current residents that utilize oxygen to evaluate the physician orderand assessment after intervention was carried out. The Unit Manager or designee will audit current residents that have receive anti-hypertensive medication to evaluate that the blood pressure and heart rate are documented per physician order. The Unit Manager or designee will audit current residents with indwelling catheters to ensure that a physician order is in place for catheter change . Audits will be completed daily until consistently reaching 100% success over three consecutive evaluations then three times then weekly until reaching 100% success over three consecutive evaluations then monthly until reaching 100% Results of these audits will be forwarded to the Quality Assurance	

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F 684	Continued From page 40 document a baseline neurological evaluation as indicated on the Neurological Evaluation Flow Sheet. 2. Notify physician of specific patient event, initial findings and baseline neurological evaluation. 3. Obtain orders for subsequent neurological evaluations...or other medical care as clinically indicated. 4. After the completion of initial neurological evaluation with vital signs, continue evaluations every 30-minutes x4...NOTE: More frequent neurological evaluations may be necessary if clinically indicated...5. Subsequent neurological evaluation should be compared to baseline and previous neurological evaluations...8. Evaluate pupils. (It may be necessary to darken room or ask patient to close eyes for 30 seconds prior to evaluation.) Upon opening eyes, use a penlight or flashlight to evaluate Pupil Size and Pupil Reaction for both the left and right eyes. Document using the following responses: E=equal pupil size, U=unequal pupil size, R=reacts to light, NR=no reaction to light. 9. Evaluate motor movement by providing patient with simple motor commands. Document "Y=Yes or N=No" responses to the following: moves right and left upper limbs, moves right and left lower limbs, facial symmetry. 10. Evaluate communication/language by providing simple communication commands. Document "Y=Yes or N=No" responses to the following: expressive aphasia, receptive aphasia, speech slurred, communication changes. 11. Evaluate for unusual/new observations. Document observation responses using the following: W=weakness, T=tremors, D=dizziness, H=headache, V=vision changes, N=numbness, O=other. 12. Evaluate vital signs. Record baseline vital signs and compare subsequent vital signs to baseline and previous evaluations. Document the following information: blood	F 684	Committee for review and evaluate need for further action times one.	

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F 684	Continued From page 41 pressure, pulse, pulse ox %...temperature, respiration rate, respiration pattern - N=normal/regular/unlabored or AB=abnormal. NOTE: Pay close attention to respiratory patterns. Notify physician regarding any "Abnormal findings or any changes in respiratory rate or pattern. NOTE: Notify physician of any neurological evaluation findings which are a change from baseline or previous evaluations...". The facility's policy entitled Oxygen Administration, dated 2017, stated, "Purpose: ...During a respiratory emergency, it is appropriate for nursing to administer oxygen immediately and obtain physician's order after patient is stabilized or transferred...". 1. Review of R379's clinical record and hospital records revealed the following: 9/30/15 - R379 was admitted to the facility with diagnoses that included Vascular Dementia and Fibromyalgia. 3/16/16 - R379 was care planned for the following: - ADL Self Care Deficit related to physical limitations/deconditioning with an approach that included to transfer with a stand-up mechanical lift and 2 staff assist. - Falls, at risk for falls due to physical limitations/deconditioning related to balance/poor coordination with approaches that included, but not limited to, low bed (initiated 4/14/16), provide assistance for transferring as needed (initiated 4/14/16) and scoop/perimeter mattress (initiated 6/14/16). 6/21/17 - The quarterly MDS assessment stated	F 684		

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F 684	Continued From page 42 that she had short-term and long-term memory problems, had no ability to recall the season/her room location/staff names or faces or that she was in a nursing home, required extensive assistance with 2 staff for transfers and was not steady - only able to stabilize with staff assistance for surface-to-surface transfer between bed and wheelchair. The assessment stated that R379 was 5 feet 1 inch tall and weighed 167 pounds. 8/13/17 at 2:45 PM - R379 fell out of wheelchair, without hitting her head. Post-fall nursing assessments, including neurological checks, of R379 revealed that she had no apparent injury or pain. Vital signs and neurological checks were stable. The facility's fall investigation stated that R379 had impaired balance/poor coordination during transitions and required foot rests for her wheelchair. 8/14/17 at 7:30 PM - R379 fell again. The facility's incident report, completed by E22 (RN), stated, "...Location of Incident: Patient's room...CNA reported that patient had a fall upon being transferred with a stand-up lift from wheelchair. On assessment, patient was noted with a hematoma on the left side of her forehead...Was physician notified? Yes...8/14/17 8:00 PM...Physician name: E26 (NP). By whom notified: E22 (RN)...Describe care and medications, if any, provided to patient following incident, and by whom provided: Neurochecks initaiated (sic). Ice pack applied to hematoma on L (left) side of face. Was patient taken to a hospital? Yes. If yes, Date: 14-Aug-2017 9:30 PM...(Family) Date notified: 8/14/17 8:30 PM...Phone conversation. Name of staff person notifying: E22 (RN)...".	F 684		

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F 684	Continued From page 43 8/14/17 at 7:40 PM - The first neurological assessment, performed by E22, revealed that R379 was alert, oriented to person; left pupil reaction had no reaction to light; right pupil reacted to light; R & L pupil sizes lacked assessment; able to move 4 limbs; facial symmetry lacked assessment; no communication/language changes were noted; unusual/new observations were not noted; vital signs: BP 155/134, pulse 91, pulse ox 99%, temperature 97.6 degrees F, respirations 18. The facility failed to perform a complete assessment of R379's neurological status. In addition, the facility failed to identify abnormal neurological findings. 8/14/17 at 8:10 PM - The second neurological assessment, performed by E22, revealed that R379's left pupil continued to have no reaction to light; R & L pupil sizes lacked assessment; R379's left lower limb movement lacked assessment; facial symmetry lacked assessment; vital signs were BP 155/111, pulse 119, pulse ox 90%, temperature 97.8 degrees F, respirations 18. The facility failed to perform a complete assessment of R379's neurological status and failed to identify abnormal neurological findings and vital signs. It was unclear in R379's clinical record whether she was administered oxygen via nasal cannula at this time when her pulse ox was 90%. 8/14/17 at 8:40 PM - The third neurological assessment, performed by E22, revealed that R379's left pupil continued to have no reaction to light; R & L pupil sizes lacked assessment; R379's left lower limb movement lacked assessment; facial symmetry lacked assessment; vital signs were BP 150/59, pulse 96, pulse ox	F 684		

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F 684	Continued From page 44 92%, temperature 97.6 degrees F, respirations 18. The facility failed to perform a complete assessment of R379's neurological status and failed to identify abnormal neurological findings. 8/14/17 at 9:04 PM - E22 recorded R379's HR 110 and pulse ox 94% on (undocumented) liters of oxygen via nasal cannula. It was unclear as to when the administration and how many liters of oxygen via nasal cannula was started as R379's clinical record lacked evidence of documentation. 8/14/17 at 9:17 PM - E22 called 911. 8/14/17 at 9:20 PM - The fourth neurological assessment, performed by E22, revealed that R379's left pupil continued to have no reaction to light; R & L pupil sizes lacked assessment; R379's left lower limb movement lacked assessment; facial symmetry lacked assessment; vital signs were BP 154/60, pulse 97, pulse ox 86%, temperature 97.1 degrees F, respirations 18. The facility failed to perform a complete assessment of R379's neurological status and failed to identify abnormal neurological findings. It was unclear how many liters of oxygen R379 was administered when her pulse ox was recorded as 86%. 8/14/17 at 9:26 PM - EMS arrived at the facility; GCS=15, ...Chief Complaint: "(name of R379) fell and hit her head when being loaded into bed" x 2 hours...Primary Symptom: Pain...Cause of Injury: Fall...Mechanism of Injury: Blunt....History: Dispatched to a nursing home for a 85 year old female...The patient was found lying semi-fowlers in her bed in the nursing home with her eyes closed...The patient's nurse walked into the room with the BLS crew and informed us that the	F 684		

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F 684	Continued From page 45 patient had fallen and hit her head while being loaded into bed. The nurse stated that the patient has dementia and is currently in her normal mental status. After a rapid assessment and noticing that the patient fell and landed on her head, a C-collar was put on to protect from further spinal injury if there is any. It was also noticed that the patient had a laceration to the left eyebrow and forehead with swelling and controlled bleeding from the left eye. It was also noticed that the patient had a small laceration on the top left of her head with older, dried up blood, possibly from the fall yesterday. The patient was then moved to the stretcher...Events prior to the incident: The patient had fallen out of bed...and the nursing home neglected to call 911 to have the patient checked out. When being loaded into bed via a standing lift and assisted by 2 facility staff members, the patient fell and landed directly on her head without using her arms to brace her fall. The patient came up with a laceration to the left forehead and eyebrow with swelling and controlled bleeding from the left eye. The patient was put back into bed and the nursing home waited for 2 hours to call 911...". 8/14/17 at 9:37 PM - EMS left facility with R379. 8/14/17 at 10:43 PM - The facility's Change of Condition NN stated, "At around (7:35 PM), staff reported to this nurse that pt had incurred a fall while being transferred using a standard lift with assist of two CNA's. Pt was observed on the floor on the right side of her bed next to the bedside lamp stand with face down. Upon assessment patient noted with a hematoma on the left side of her face and with some slight bloody discharge from her left eye. Assessed B/L upper and lower extremity for deformities none noted. Range of	F 684		

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F 684	Continued From page 46 motion performed on all limbs no s/s of pain or distress noted. Neuro checks initiated and vital signs checked as ordered. Patient responds, but with confusion that is within baseline. E26 (NP) on call for (E3, physician) made aware at (8:30 PM) and new order given to send patient out to (hospital) for Evaluation. Family notified. Paramedics transferred patient from facility at around (9:30 PM)." 8/14/17 - The facility's investigation revealed the following: - E22 (RN) stated she was assigned to care for R379; she found R379 on the floor in a prone position; R379 was "incoherent (sentences were not clear)" when R379 was asked what she was doing when she fell; R379 was "within baseline" with respect to her behavior during the shift (prior to the fall); and stated, "Patient was in prone position rolled to back and transferred to bed". - E28 (CNA) stated she witnessed R379 fall; R379 exhibited "normal" behavior during the shift (prior to the fall); and R379 was "leaning on the left side". - E29 (CNA) stated, "...R379 leaned to the left and forward and fell face first to the floor. E28 was unable to get to R379 because she had to back up a little bit for me to move the stand-up lift out of the way. R379 laid there for a couple of seconds then she shook almost like she was having a seizure then she yelled 'help, help I'm cold'. E28 ran out and got the nurse (E22) right away. E22 came and asked what happened, we told her what happened, E22 assessed the patient, and we got E30 (CNA) to come help us. We put a flat sheet under the patient and we picked R379 off the floor and back to bed. E22 put ice on R379's head. R379 continued with the shaking and yelling even when we did vital signs.	F 684		

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F 684	Continued From page 47 R379 fell around 7:35 and after she was settled in bed it was going on 8 PM." - E30 (CNA) stated that she saw R379 "laying on her belly". - E31 (RN) stated that she did not observe R379 on the floor and answered "I don't know" to the question to describe the environment. 8/15/17 at 12:51 AM - The hospital's TRAUMA H&P stated, "...Patient...subsequently fell forward impacting her head and hyperextending her neck. She sustained a hematoma to the L forehead with associated ecchymosis about the L eye. In the ED patient underwent a CT of the head and C-spine. CT of the head was notable for a large left frontal subgaleal hematoma as well as a left parietal hematoma, however there were no obvious fractures or intracranial bleeding noted. CT of the C-spine was notable for a Type II odontoid fracture with approximately 5mm of distraction cut without significant subluxation...Disposition: ...She will be admitted to TSU for serial neuro checks, hard cervical collar, spine surgery consultation...". 8/15/17 at 7:20 AM - The facility's post Fall Assessment after R379's fall on 8/14/17 at 7:35 PM stated that her physical performance limitations included difficulty maintaining sitting balance and impaired balance during transitions; and diagnoses included cognitive impairment and dementia. 8/15/17 at 10:54 AM - The hospital's H&P stated, "...History of Present Illness: ...suffered a fall...History is limited by her current mental status and most information is obtained from the chart. She was apparently in her normal state of health prior to the fall. It was witnessed by a staff	F 684		

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F 684	Continued From page 48 member who reported that she hyperextended her neck. In the ED, she was found to have an odontoid fracture and a significant amount of bruising around the left eye. Since admission to the trauma service, she has also been found to have a vertebral artery dissection...". 8/15/17 at 11:19 AM - The hospital's neurosurgery consult note stated, "...Neurosurgery was consulted for evaluation of her type II odontoid fracture...Patient is rather lethargic, and is having difficulty maintaining conversation...Assessment/Plan: ...She was found to have a type II odontoid fracture with 5mm of distraction and slight anterior displacement of C2. These represent unstable fractures, and are usually treated with an odontoid screw placement for stabilization. Patient is not on anticoagulation. She does have an injury/dissection of the...vertebral artery for which aspirin is the treatment. She already takes an aspirin 81mg at home. Dose will be increased to 162mg and a repeat CTA in 6 weeks for re-evaluation per neuro IR...(neurosurgeon) would like to take patient to OR for placement of odontoid screw...". 8/16/17 at 9:09 AM - The hospital's Progress Note stated, "...admitted s/p fall with odontoid fx s/p ORIF with screw last evening, has had increasing lethargy along with hypotension and bradycardia overnight. Concerned that she is unable to protect her airway...(family) made the decision to make her a DNR with the limitations indicated in the orders...". 8/16/17 at 5:16 PM - The hospital's Progress Note stated, "During AM report pt only arousing to pain and not able to follow	F 684		

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F 684	Continued From page 49 commands...Throughout day pt (patient) at times awakens to voice and basic neuro able to (sic) completed other times requiring nail bed pressure to withdraw...". 8/17/17 at 11:40 AM - The hospital's Discharge Summary stated, "...Discharge Diagnoses: Type II odontoid fracture status post ORIF and screw AND Vertebral artery dissection...Hospital Course: ...Patient had CAT scans of the head and cervical spine was identified she had a type II odontoid fracture neurosurgery was consulted as well as neuro interventional post CTA of the neck. (Neurosurgeon) discussed with family risk and benefits of surgery and was decided patient will go on to have an ORIF of the odontoid fracture with screw. Post surgery patient lethargic not swallowing or waking for any nutrition. Patient also with episodes of bradycardia and hypotension...On day of her discharge patient more awake speaking able to tolerate oral liquids...Significant Labs/Imaging/Diagnostic Tests: Patient will need follow-up for her vertebral artery injury recommending CTA of the neck on 10/1/17...Medications at Discharge: CHANGED...Aspirin 81mg EC - take 2 tabs daily for your vertebral artery dissection...Additional Instructions Given to Patient: Patient may wear a soft collar for comfort measures. Recommended for her long-term facility at (name of facility) to monitor her blood pressure and heart rate before giving her antihypertensive medications...". 8/17/17 at 1 PM - R379 was discharged from the hospital and returned to the facility. 8/17/17 at 1:30 PM - The facility's NN stated that R379 was readmitted from hospital with diagnoses of Type 2 Odontoid FX, left frontal	F 684		

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F 684	Continued From page 50 hematoma and left posterior parietal hematoma. 8/22/17 untimed - The facility's physician progress note stated, "...Impression/Plan: 1) Type II Odontoid Fx - s/p ORIF. F/U c surgery, pain control. 2) R Vertebral Artery Dissection...". 2/26/18 at 5:30 PM - During an interview, E28 (CNA) stated the following regarding the 8/14/17 fall: - she was the spotter; - she was too short to stand on the other side of R379's bed so she stood to the right side and behind the stand-up lift as she was blocked because the stand up lift was next to the dresser which was closest to the HOB; - when E39 moved the stand up lift away from the bed, R379 fell forward as she was sitting on edge of bed and landed on the tiled floor; - vital signs were taken and 4 staff placed R379 on a sheet and transferred her to the bed; - the hoyer lift was in the Medbridge unit; - the resident was alert and talking during the transfer; - E28 demonstrated the position of the stand-up lift, where she was standing, and how high the bed was elevated in order to use the stand-up lift so it would not get stuck under the bed frame. It was approx. 24 inches from the top of the regular mattress (used in the demonstration) to the floor. 2/26/18 at 6:03 PM - During an interview, E29 (CNA) stated the following regarding the 8/14/17 fall: - she was operating the stand up lift; - R379 was already leaning forward in the wheelchair before the transfer; - the night stand was not next to the bed, but moved away from the bed;	F 684		

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F 684	Continued From page 51 - E28 was on the right side as the lift was being pulled out and that she moved back to get out of the lift's way; - R379's feet were not on the the ground and she fell hitting the left side of her face; - R379 kept saying "help, I'm cold"; - E28 went to get E22 (RN); - E22 assessed R379 on the floor; - E29, E28, E22 and E30 (CNA) used a sheet to transfer R379 from the floor to the bed; - Once in bed, she observed R379 shaking (looked like seizing) for approx. 30 to 45 minutes; - E22 placed ice on R379's head then went to call someone; - the 3-11 PM shift house supervisor, E31, was on a medication cart on the Linden unit; - R379 was complaining that her "head was hurting" after the fall; - the CNA's were upset that it took 2 hours for R379 to be sent out to the ER and she didn't know why it took so long; and - she knew the resident very well. 2/28/18 at 1:11 PM - During a telephone interview, E22 (RN) stated the following regarding the 8/14/17 fall: - E28 told her that R379 was on the floor; - observed R379's face was on the floor near the dresser; - R379 was saying, "get me up, get me up, I'm cold"; - asked R379 if she fell and R379 said she could not remember; - R379 was on her left side and she took her vitals and couldn't get her BP and took it again and it was 150 over something; - looked for ROM for injuries and then noticed swelling and hematoma; - They (E22, E28, E29, E30) got her on the bed	F 684		

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F 684	Continued From page 52 and took another vital signs and neuro checks; - Noticed R379 had bloody drainage from her left eye and took her BP again and it had dipped a little bit and she was concerned; - Could not remember, but believed R379 was on a baby aspirin, but was a bit concerned with the swelling and the BP going down; - Called the doctor and left message for call back; - E26 (NP) called back and she provided her assessment; - E22 stated that she told E26 she thought they needed to send R379 out just to be on the safe side because she hit her head and has a hematoma. E22 told E26 of the bloody drainage on her left eye and started to wonder if it could be a subdural hematoma. The discharge was a "clear bloody discharge". E26 told E22 that you are with the patient, so let's send her out; - E22 said what got her concerned was the dropping BP, which prompted her to call for the paramedics who came, assessed her and took her. - E22 said the CNAs told her that R379's fall was not during the transfer. R379 was already on the bed. E22 questioned the CNAs and they told her that R379 did not fall from the lift. - E22 confirmed that they used a sheet to transfer R379 from the floor to the bed; - E22 stated that R379 kept saying to get her off the floor and she was laying face down in a fetal position and E22 was trying to figure out how she was going to get her up to the bed. - E22 stated that once off the floor, she felt she could properly look at R379. - E22 stated that E29 stayed with R379 in the room; - E22 stated the nurse gets the first set of vitals then the CNA stays in the room and gets the vitals from that point and anything of significance,	F 684		

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F 684	Continued From page 53 the CNA will get the nurse who will do another set of vitals. - E22 stated she went back to the Nurse's Station and placed the call and waited for a call back. - E22 confirmed that E26 (NP) called back at 8:30 PM and gave the order to send R379 to the ER. - When asked who put R379's paperwork together, E22 could not remember. - When asked who called 911, E22 could not remember. - E22 stated first blood pressure was taken while on the floor. - E22 stated that she had R379 move her legs and arms. - E22 said when she turned R379 over, she noticed the hematoma and not the bloody eye drainage until they got her in bed. E22 confirmed there were no eye issues prior to the fall. - When asked if transferring a resident via sheet was normal practice at the facility, E22 said no. - E22 said because of her position, they could not get a lift to her as they could not get it between the dresser and the bed. - When asked if the dresser was next to the bed, E22 said yes and she was concerned about pulling R379 back. - When asked about immobilizing the resident after the fall, E22 stated that R379 said she was okay. E22 then said that she did not notice the hematoma until she got her in bed. - E22 said that if there is obvious injury they usually let the paramedics move them. - When asked if E22 went about her other duties until the ambulance arrived, E22 stated that this is a priority, however she has to look at other patients too. Being on the Arcadia Unit, they have to keep an eye on the other patients who wander into other rooms. - When asked about who recorded the BPs as	F 684		

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F 684	Continued From page 54 only 5 BPs were noted during the 2 hour timeframe, E22 did not respond. - When asked about the first neurological check where her left eye was non-reactive to light and if that was a concern, E22 said that was a concern, but could not offer an explanation. - When the surveyor pointed out that the fall occurred at 7:30 PM, E22 received a call back from E26 (NP) at 8:30 PM with an order to send R379 to the hospital, and the medics arrived at 9:30 PM, why was there a delay in sending her out, E22 said "she can't remember". - When asked if any other nurse, including the house supervisor, was involved in R379's care after her fall, E22 could not recall. E22 stated she was the only nurse on the Arcadia Unit. When asked about the Medbridge Nurse, E22 stated that it was a critical time for her to be passing meds and doesn't remember her being involved. - When asked if it was the facility's practice to move a resident back to bed when they have fallen and landed on their face, E22 said yes if done safely. When asked even if the resident was cognitively impaired, E22 said she can tell you if she was in pain. - When asked if it ever entered E22's mind that R379 could have injured her head and neck before they moved her, E22 said she would not move anyone if there is suspected injury. E22 stated that she depended on being told by the CNAs as to what happened and knew she did not fall from the lift. - When asked about her dependence on being told by the CNAs as to what happened and the CNAs said she fell from the bed, E22 said she didn't bother to look at the height of the bed and that she was more interested in the resident. 3/1/18 at 5:50 PM - Findings were reviewed	F 684		

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F 684	Continued From page 55 during the Exit Conference with E1 (NHA) and E2 (DON). For R379, the facility failed to perform complete neurological assessments of R379 after her 8/14/17 fall; failed to identify abnormal neurological assessment findings; failed to consider the potential of head and/or cervical trauma based on the blunt mechanism of R379's fall, the assessment observations of R379's laceration to the left eyebrow and forehead, swelling and hematoma on the left side of her face, incoherent sentences after the fall, and unstable vital signs; and failed to immediately call 911 to transfer her to the Emergency Room (ER) for evaluation and treatment after a physician's order was received at 8:30 PM, and instead waited for an additional 47 minutes to call 911 at 9:17 PM, resulting in a delay in treatment and care. R379 was received and assessed as a Trauma Code in the ER, underwent surgery for placement of a screw for her Type II Odontoid Fracture and diagnosed with a Vertebral Artery Dissection. 1b. Review of R379's clinical record and facility documents revealed the following: 8/17/17 at 11:40 AM - The hospital's Discharge Summary stated, "...Recommended for her long-term facility [name of] to monitor her blood pressure and heart rate before giving her anti-hypertensive medications...". 8/17/17 to 12/6/17 - R379's clinical record lacked evidence of monitoring her blood pressure and heart rate before administering her two anti-hypertensive medications. 8/21/17 untimed - The facility's physician	F 684		

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F 684	Continued From page 56 progress note stated under the Impression/Plan for R379's hypertension was to monitor her blood pressure. 3/1/18 at 9:50 AM - During an interview, E4 (SDC) confirmed the findings. The facility failed to monitor R379's blood pressure and heart rate before administering her two anti-hypertensive medications from 8/17/17 through 12/6/17 (110 days). 3/1/18 at 5:50 PM - Findings were reviewed during the Exit Conference with E1 (NHA) and E2 (DON). 1c.. Review of R379's clinical record revealed the following: 12/6/17 at 2:14 PM - A telephone physician's order was received and stated to apply oxygen at 2 liters via nasal cannula, may titrate to keep pulse ox greater than 92% every shift. 12/6/17 at 2:34 PM - A NN from day shift stated that R379's pulse ox was 88% and oxygen was applied via nasal cannula. R379's pulse ox was rechecked and revealed 90% on 2 liters. 12/6/17 during 3-11 PM shift - R379's clinical record, including NN and eTAR, lacked evidence that R379's pulse ox was rechecked and titrated to keep R379's oxygen level greater than 92% during the shift. The facility failed to follow a physician's order. 12/7/17 at 2:11 AM - The eMAR revealed that R379 was administered an albuterol nebulizer [breathing treatment] for shortness of breath and decreased pulse ox.	F 684		

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F 684	Continued From page 57 12/7/17 at 6:59 AM - A NN from night shift stated, "Approximately 0100, nurse went to patient room, noted patient with labored breathing, with difficulty breathing. Nurse assessed patient POX noted to bed (sic) 69% at 2L/NC. Nurse adjusted patient O2 and pox came to 96% and then dropped to 83%. E32 (on call NP) notified and gave n/o for albuterol...for SOB...". 3/1/18 at 9:50 AM - During an interview, E3 (physician) stated that the issue with low pulse ox on 12/6/17 during 3-11 PM shift sounded like a documentation problem. E3 stated that yes, he would have expected the nurse to reassess R379's pulse ox. 3/1/18 at 5:50 PM - Findings were reviewed during the Exit Conference with E1 (NHA) and E2 (DON). The facility failed to follow a physician's order to monitor pulse ox and titrate R379's pulse ox greater than 92% on 12/6/17. 4. Review of R88's clinical record revealed the following: The facility's policy entitled Catheter Care: Indwelling Catheter, last revised 4/2016, stated, "...Procedure: 1. Verify physician's order...". 11/23/17 - R88 was admitted to the facility with a diagnosis of neurogenic bladder requiring the use of an indwelling catheter. 11/23/17 to 2/23/18 - R88's clinical record lacked evidence of a physician's order to change her indwelling catheter. 2/2/18 at 3:29 PM - A NN stated that R88's	F 684		

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F 684	Continued From page 58 indwelling catheter was changed during the day shift. The facility failed to verify that R88 had a physician's order before changing her indwelling catheter. 2/10/18 at 9:54 PM - A NN stated that R88's indwelling catheter appeared clogged and was changed. The facility failed to verify that R88 had a physician order before changing her indwelling catheter. 2/26/18 at 5:06 PM - During an interview, E6 (UM) and E7 (UM) confirmed that R88 did not have a physician's order to change her indwelling catheter and confirmed that her indwelling catheter was changed. The facility failed to have a physician's order to change R88's indwelling catheter and failed to verify that R88 had a physician order two times before changing her indwelling catheter. 3/1/18 at 5:50 PM - Findings were reviewed during the Exit Conference with E1 (NHA) and E2 (DON).	F 684		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to	F 688		4/25/18

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F 688	Continued From page 59 prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on record reviews, interviews and review of facility documentation, it was determined that for two (R88 and R60) out of 55 sampled residents with limited ROM and limited mobility, the facility failed to ensure appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion; and failed to ensure appropriate services, equipment and assistance to maintain mobility with the maximum practicable independence unless a reduction in mobility was demonstrably unavoidable. Findings include: 1. Review of R88's clinical record revealed the following: 11/23/17 - R88 was admitted to the facility for short-term rehabilitation. 11/29/17 - R88 was care planned for at risk for loss of range of motion related to immobilization, physical limitations and multiple sclerosis. R88 was receiving skilled physical therapy. 1/11/18 - R88 was discharged from skilled physical therapy services as she had reached the maximum functional level. R88 was placed on a restorative program with 3 specific exercises twice a day to promote her lower extremities range of motion and to minimize contractures.	F 688	It is the intent of the facility to ensure that when a resident is admitted in the facility does not experience reduction in range of motion unless the resident□s clinical condition demonstrates that a reduction in range in motion is unavoidable. A. Resident # 88 no longer resides in the facility.Resident #60 □s restorative program was reviewed and revised on 3/30/18 for further restorative needs. B. The Unit Manager or designee will audit current residents that have been discharged from therapy since 3/1/18 and residents currently in therapy to ensure the restorative program is in place as identified by the therapy discharge communication tool. C. System changed that facility staff will provide all recommended therapy and restorative programs. The Staff Development Nurse educate the Unit Managers regarding utilization of the therapy discharge communication tool to implement a nursing restorative program. D. The Unit Manger or designee will audit current residents that have been	

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F 688	Continued From page 60 1/12/18 to 2/23/18 - Review of R88's clinical record lacked evidence that she received the above restorative services, specifically the 3 exercises, for her lower extremities as per her plan of care. 2/26/18 at 5:06 PM - During an interview, E7 (UM) confirmed the findings. The facility failed to provide R88, a resident with limited range of motion, with appropriate treatment and services for her lower extremities to increase range of motion and/or to prevent further decrease in range of motion. 3/1/18 at 5:50 PM - Findings were reviewed during the Exit Conference with E1 (NHA) and E2 (DON). 2. Review of R60's clinical record revealed the following: 4/6/16 - R60 was admitted to the facility with a diagnosis of hemiplegia and hemiparesis after a stroke. 4/7/16 - R60 was care planned for range of motion (last reviewed 7/25/17), included the goal - will exhibit no decline in range of motion, and the intervention - therapy evaluation and treatment as ordered/needed. 2/14/17 - The physician's Progress Note stated that "Pt (patient) is working again with therapy. Is getting to where he can stand...". 3/29/17 - The annual MDS assessment stated that R60 required extensive assistance with one person assist for locomotion on the unit; required total dependence with one person assist for	F 688	discharged from therapy to ensure the therapy discharge communication tool to prevent and a nursing restorative program is implemented. Audits will be completed daily until consistently reaching 100% success over three consecutive evaluations then three times then weekly until reaching 100% success over three consecutive evaluations then monthly until reaching 100%. Results of these audits will be forwarded to the Quality Assurance Committee for review and evaluate need for further action times one.	

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F 688	Continued From page 61 locomotion off the unit; and his mobility devices included a walker and wheelchair. 5/1/17 - The physician's Progress Note stated, "He is now able to walk 30 feet with a walker...". 5/12/17 - The Physical Therapy Discharge Summary stated that R60: - propelled self in wheelchair: baseline distance on 12/12/16 was 20 feet, and discharge distance on 5/12/17 was discontinued on 1/19/17; and - safely ambulated - baseline distance on 12/12/16 was 20 feet, and current distance upon discharge on 5/12/17 was 25 feet. 9/26/17 - The Physical Therapy Progress Report stated that R60: - propelled self in wheelchair: baseline distance on 7/6/17 was 20 feet, and current distance on 9/26/17 was 50 feet; and - safely ambulated - baseline distance on 7/6/17 was 0 feet, and current distance on 9/26/17 was 30 feet. 9/27/17 - The quarterly MDS assessment stated R60 required total dependence with one person assist for locomotion on and off the unit; and his mobility devices included a walker and wheelchair. 9/29/17 - The Physical Therapy Discharge Summary stated that R60 made consistent progress throughout the POT (plan of treatment), has made consistent progress with skilled interventions, and made substantial functional gains in response to skilled interventions and his functional abilities have progressed as a result of the skilled interventions. R60's prognosis to maintain his current level of function was good	F 688		

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F 688	Continued From page 62 with consistent staff follow-through. A Discharge Communication Form was completed. 9/29/17 - The Physical Therapy Treatment Encounter Note stated, "Patient will be discharged to restorative exercise...". 10/26/17 - The Rehabilitation Screening Form stated, "Patient previous on discharge from PT...Presently...unable to move right lower extremity in order to ambulate. Benefit PT to return to PLOF (prior level of functioning)." 11/3/17 - The physician's Progress Note stated, "...wants to restart therapy...told that he can get PT episodically as needed for specific issues." 12/19/17 - A Rehabilitation Screen Form stated no screening results. 12/27/17 - The quarterly MDS stated that R60 required total dependence with one person assist for locomotion on and off the unit; and his mobility device included a wheelchair. During an interview on 2/22/18 at 12:24 PM, E13 (Social Worker) stated R60 was now in long term care and would not continue indefinitely with physical therapy. If staff notice a change in the resident, he would be re-evaluated for physical therapy. During an interview on 2/23/18 at 9:45 AM, E9 (Rehab Director) stated R60 had physical therapy from October 2016 until May 2017, and then again from July 2017 to September 2017. E9 stated R60 was anticipating to be discharged to home, but his family was unable to care for him at home. When asked how the facility ensures R60	F 688		

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F 688	Continued From page 63	F 688		

maintains physical therapy gains, E9 stated nursing staff will do active range of motion. E9 stated if nursing notices a change in the resident's abilities, or the MDS assessment shows a change in ability, PT would re-evaluate at that time.

During an interview on 2/27/18 at 8:35 AM, E14 (UM) stated nursing would follow PT's recommendations on the Therapy Discharge Communication Form. E14 confirmed there was no Discharge Communication Form for R60 following his 9/29/17 discharge from PT.

During an interview on 2/27/18 at 10:49 AM, E15 (Physical Therapist) stated that once he completed the Rehabilitation Screening Form, he would place it in the chart on R60's floor and flagged it to be reviewed.

During an interview on 2/27/18 at 1:25 PM, E9 stated that the comment "Patient will be discharged to restorative exercise...", on the 9/29/17 Physical Therapy Treatment Encounter Note was meant that R60's wife was responsible to do the restorative exercises with R60. E9 stated R60 and his wife were given equipment and a list of exercises to complete. E9 stated R60 and his wife never did the exercises and returned the equipment to physical therapy. E9 could not produce any documentation to corroborate this statement.

During an interview on 2/27/18 at 2:58 PM with R60's wife, she stated she was not instructed on doing any exercises with R60, nor was she given any written instructions. R60's wife stated she has a bad back and would not be able to do the exercises. R60's wife stated she was under the

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F 688	Continued From page 64 impression that someone from physical therapy would be coming to use the leg weights and bands that were stored in R60's closet. R60's wife stated after awhile she brought the equipment back to physical therapy. Findings were reviewed with E1 (NHA) and E2 (DON) on 3/1/18 at 1:30 PM. The facility failed to provide restorative services and assistance to maintain and/or improve mobility to the maximum practicable independence for R60 after he was discharged from physical therapy on 9/29/17.	F 688		
F 725 SS=D	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides.	F 725		4/25/18

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F 725	Continued From page 65 §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observations and interview, it was determined that the facility failed to have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population. For R13, the facility failed that ensure that sufficient staff were present to assure resident safety. Findings include: Review of R13's clinical records revealed the following: R13 was admitted to the facility on 8/19/16 with diagnoses that included Alzheimer's disease, anxiety and depression. R13 resided on the facility's Arcadia unit (locked dementia unit). Review of R13's clinical record revealed the resident had a history of falls. 8/20/16 - A care plan, last revised 9/13/17, for the problem at risk for falls was developed. Interventions included encourage to transfer and change positions slowly, patient ambulated related to restlessness, provide assist to transfer and ambulate as needed, redirect with activities, for example folding towels. The following observations were made of R13:	F 725	It is the intent of the facility to ensure that sufficient staff to maintain the highest practicable physical, mental and psychosocial well-being of each resident. A. Resident #13 was not negatively impacted by this practice. B. All Residents are provided sufficient staffing to meet the needs of their needs. c. In order to protect other residents in similar situations the facility will conduct staffing meetings to validate that mandated PPD is met and sufficient staff present to meet the resident□s needs throughout the facility on a 24 hour basis.¿ The Staff Development Coordinator¿ ¿will conduct in servicing to nursing staff regarding the importance of tending to the residents needs while the residents are in the level 1/activity room. D. The Unit Manager or designee will audit the staffing meeting minutes. The Unit Manager or designee will audit the level 1 dining/activity room to ensure nursing staff is present and monitoring the residents present. Audits will be completed daily until consistently reaching 100% success over three consecutive evaluations then three	

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F 725	Continued From page 66 2/20/18 at 4:20 PM - Fourteen residents were observed in the Arcadia lounge. The TV was playing but no one was watching the program. There was one staff (E19) present in the room, who was working on charting. There was no additional staff present engaging with the residents. R13, who had a history of standing and walking unassisted, was observed to have removed her non skid slipper socks which presented a potential risk for falling. 2/23/18 at 8:32 AM - R13 was seated in a wheelchair in the lounge area with her wheelchair unlocked. R13 was observed attempting to either stand or move her wheelchair forward resulting in her sliding to the front of the wheelchair. There was no staff present in the room to provide supervision. The surveyor informed E25 (LPN) who was outside the room pouring medications. E25 immediately came into the room, placed R13 at a table and locked the wheelchair. 2/26/18 approximately 3:10 PM - R13, who was only wearing one non skid slipper sock, was observed standing up from her wheelchair, which was not locked, and ambulating unsteadily toward the piano. Upon turning around, R13 became more unsteady. There was only E19 (Activity Assistant) in the room doing an activity with other residents in a circle with her back towards R13. The surveyor waved down E19 to alert her that R13 was ambulating unsteadily. 2/27/18 at 11:07 AM - R13 was seated in a circle with 15 other residents. There was only E20 (Activity Assistant) in the room doing an activity with other residents in a circle with her back towards R13. Unobserved by E20, R13 stood up	F 725	times then weekly until reaching 100% success over three consecutive evaluations then monthly until reaching 100%. Results of these audits will be forwarded to the Quality Assurance Committee for review and evaluate need for further action times one.	

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F 725	Continued From page 67 from her wheelchair. A resident seated next to R13 began clapping her hands to alert E20 that R13 was standing. There were no additional staff present to supervise other residents while E20 conducted the activity. The facility failed to ensure that sufficient staff were present to assure resident safety. Findings were reviewed with E2 (DON) on 3/1/18 at 12:15 PM. E2 stated that she believed that the facility had sufficient staffing, as they always met Eagles Law requirements. The surveyor informed E2 that Eagles Law was for minimum staffing requirements and did not take into account the needs and acuity of the residents.	F 725		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, it was determined that for one (R137) out of 55 sampled residents, the facility failed to ensure that the resident was free from any significant medication errors. R137 received two daily doses of Coumadin, an anticoagulant, after the resident returned from the hospital without Coumadin orders due to the resident having a subdural hematoma. Findings include: Review of R137's clinical record and facility documents revealed: R137 was admitted to the facility on 12/9/17 with diagnoses that included chronic atrial fibrillation	F 760	It is the intent of the facility to ensure that the residents are free of any significant medication errors. A. Resident #137 no longer resides in the facility. B. The Unit Manager or designee will audit current residents that are on anticoagulants, validating that those residents do not have a diagnosis of subdural hematoma/hemorrage. If a diagnosis of subdural hematoma/hemorrage is found, the	4/25/18

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F 760	Continued From page 68 and was receiving Coumadin therapy with changes per PT/INR. On 1/19/18, R137 was discharged to the hospital status post fall with head injury and was re-admitted back to the facility on 1/21/18 with a diagnosis of a subdural hematoma. Discharge orders for R137 from the hospital did not include orders for Coumadin or a PT/INR. A progress note by E21 (NP) on 1/23/18 at 1:50 PM stated that Coumadin was discontinued for now. According to the incident report from the incident on 1/22/18, when E23 (phlebotomist) was in the facility on 1/22/18, lab work for a PT/INR was drawn on R137 without a physician's order. When interviewed by E2 (DON), E23 stated that she did not realize R137 had been hospitalized and she was used to drawing his blood. The lab courier picked up the blood sample and later in the day the lab called to inform the facility the date of birth was missing on the specimen and they needed to redraw R137's blood. Nursing put in a lab requisition for the PT/INR redraw, although there was not a physicians order. R137's labs were redrawn on 1/23/18 by E23 without a physician's order. On 1/23/18, E22 (RN) called E24 (NP) with R137's PT/INR results and received orders via telephone for R137 to receive Coumadin 2 mg by mouth at bed time and for a PT/INR to be drawn every night shift until 1/24/18. R137 was administered Coumadin 2mg at bedtime on 1/23/18 and 1/24/18. Coumadin was discontinued on 1/25/18 and a	F 760	physician will be notifed and orders requested for continuing or discontinuing coumadin. C. The Staff Development Nurse or designee will educate licensed nurses regarding the contraindication of anticoagulation therapy utilization with the diagnosis of subdural hematoma/hemorrage and need of physician notification and order clarification in the presence of an anitcoagulant with this diagnosis. D. The Unit Manger or designee will audit current residents that receive anticoagulant therapy and have a diagnosis of hematoma/hemorrage for appropriate physician notification. Audits will be completed daily until consistently reaching 100% success over three consecutive evaluations then three times then weekly until reaching 100% success over three consecutive evaluations then monthly until reaching 100%. Results of these audits will be forwarded to the Quality Assurance Committee for review and evaluate need for further action times one.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 69 stat PT/INR was drawn with normal results. A physicians order was placed for R137 that stated no Coumadin due to subdural hematoma. The facility failed to ensure R137 was free from any significant medication orders as evidenced by R137 receiveing a daily dose of Coumadin 2 mg on 1/23/18 and 1/24/18 when R137 was not to resume Coumadin due to a subdural hematoma. During the Exit Conference on 3/1/18 at approximately 5:15 PM, findings were reviewed with E1 (NHA) and E2 (DON).	F 760		
F 773 SS=D	Lab Srvcs Physician Order/Notify of Results CFR(s): 483.50(a)(2)(i)(ii) §483.50(a)(2) The facility must- (i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. This REQUIREMENT is not met as evidenced by: Based on record review, it was determined that for one (R137) out of 55 sampled residents, the facility failed to obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist. Findings include:	F 773	It is the intent of the facility to provide laboratory services only when a physician order is obtained. A. R# 137 no longer resides in the facility. B. The Unit Manager or designee will	4/25/18

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	085033	A. BUILDING _____ B. WING _____	03/01/2018

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F 773	Continued From page 70 Review of R137's clinical record and facility documents revealed: R137 was admitted to the facility on 12/9/17 with diagnoses that included chronic atrial fibrillation and was receiving Coumadin therapy with changes per PT/INR. On 1/19/18, R137 was discharged to the hospital status post fall with head injury and was re-admitted back to the facility on 1/21/18 with a diagnosis of a subdural hematoma. Discharge orders for R137 from the hospital did not include orders for Coumadin or a PT/INR. According to the incident report from the incident on 1/22/18, when E23 (phlebotomist) was in the facility on 1/22/18, lab work for a PT/INR was drawn on R137 without a physician's order. When interviewed by E2 (DON), E23 stated that she did not realize R137 had been recently hospitalized and was used to drawing his blood. The lab courier picked up the blood sample and later in the day the lab called to inform the facility the date of birth was missing on the specimen and they needed to redraw R137's blood. Nursing put in a lab requisition for the PT/INR redraw, and there was no physicians order. R137's labs were redrawn on 1/23/18 by E23 without a physician's order. The facility failed to obtain laboratory services only when ordered by a physician two times (1/22/18 and 1/23/18). During the Exit Conference on 3/1/18 at approximately 5:15 PM, findings were reviewed with E1 (NHA) and E2 (DON).	F 773	audit current residents with laboratory draws ordered since 4/1/18 to present to evaluate the presence of a physician order. C. DON reported incident to the contract laboratory at the time of the incident. Contrated laboratory stated that education was given to their staff member involved. The Staff Development Nurse or designee will educate licensed nurses regarding the need of a physician order for all laboratory draws. D. The Unit Manager or designee will conduct ongoing audits, as outilined below, of current residents with laboratory draws to ensure a physician order is present. Audits will be completed daily until consistently reaching 100% success over three consecutive evaluations then three times then weekly until reaching 100% success over three consecutive evaluations then monthly until reaching 100%. Results of these audits will be forwarded to the Quality Assurance Committee for review and evaluate need for further action times one.	
F 804	Nutritive Value/Appear, Palatable/Prefer Temp	F 804		4/25/18

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F 804 SS=E	Continued From page 71 CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observations, resident interviews and test tray results, it was determined that the facility failed to provide food at a palatable temperature. Findings include: 2/20/18 at 9:40 AM - During an interview, R145 stated that the food was always cold during every meal. 2/21/18 at 9:21 AM - During an interview, R22 stated that the food was cold, especially the soup. 2/27/18 at 12:10 PM - Observation in the kitchen, prior to the trays leaving to go to the 2nd floor dining room, the food temperatures were as follows: chicken- 160.0 F, broccoli- 178.0 F, and chicken noodle soup- 207.4 F. The trays arrived on the 2nd floor dining room at 12:23 PM. 2/27/18 at 12:50 PM - The last try was passed out on the 2nd floor dining room, and a test tray was sampled by two surveyors for temperature and palatability. The food temperatures were as follows: chicken- 130 F, broccoli- 115 F, chicken noodle soup- 149 F, hot coffee - 102 F, pudding- 60 F, grape juice- 56 F, and cold decaf coffee- 53	F 804	It is the intent of the facility to provide meals that have nutritive value/appearance, palatable and preferable temperature. A. Resident # 145 was not negatively impacted by this practice.Resident # 22 no longer resides in the facility. B. Residents receiving oral nutrition have the potential of being affected by this practice. C. The Staff Development Nurse or designee will educate nursing staff regarding passing meal trays timely to ensure that food is served at a palatable temperature. D. The Unit Managers or designee will complete test tray audits of meal delivery trays by physically tasting the food and evaluating if its temperature is warm enough to be considered palitable. Unit Managers or designee Will also audit meal delivery service time. Residents will	

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F 804	Continued From page 72 F. The food was determined to be unpalatable. During the Exit Conference on 3/1/18 at approximately 5:15 PM, findings were reviewed with E1 (NHA) and E2 (DON). The facility failed to provide food at a palatable temperature.	F 804	be surveyed ongoing at each resident council meeting regarding if their food is warm enough to be palitable. Results will be recorded in the resident council minutes and any trends will be brought to the QAPI committee for further review and action. Audits will be completed daily until consistently reaching 100% success over three consecutive evaluations then three times then weekly until reaching 100% success over three consecutive evaluations then monthly until reaching 100%. Results of these audits will be forwarded to the Quality Assurance Committee for review and evaluate need for further action times one.	
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	F 812		4/25/18

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F 812	Continued From page 73 serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, it was determined that the facility failed to ensure that food/items were protected from contamination. Findings include: During the initial tour of the kitchen on 2/20/18 at 8:08 AM, the following observations were made: 1) open cart in the walk-in refrigerator with one large rectangular pan containing uncovered bowls of sliced peaches and pears, and one unwrapped small plate of sliced cake, and 2) large scoop inside a tall covered plastic bin containing sugar. A follow-up visit to the kitchen on 2/20/18 at 11:15 AM found the ice machine cover not closing properly; the lid was not making tight contact with the ice machine. Findings were reviewed with E1 (NHA) and E2 (DON) on 3/1/18 at 5:15 PM during the Exit Conference. The facility failed to ensure that food/items were protected from contamination.	F 812	It is the intent of the facility to store, prepare, distribute and serve food in accordance with professional standards for food service safety. A. No residents were identified by this practice. The peaches, pears and slice of cake that were uncovered were discarded on 2/20/18. The large scoop was removed from the bin that contained sugar and the sugar was discarded on 2/20/18.A new hinge was ordered and installed on 4/5/18. B. All residents have the potential of being affected by this practice. C. The Dietary Manager or designee will educate the dietary staff, licensed nurses, and certified nursing assistants regarding appropriate storage of food and food procurement. D. The Dietary Manager or designee will audit the kitchen, internet cafe and nourishment rooms for unlabeled and uncovered food items as well as storage bins to ensure proper placement of scoops. The Dietary Manager or designee will audit the ice machine cover to ensure the lid is closing properly. Audits will be completed daily until	

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F 812	Continued From page 74	F 812	consistently reaching 100% success over three consecutive evaluations then three times then weekly until reaching 100% success over three consecutive evaluations then monthly until reaching 100%. Results of these audits will be forwarded to the Quality Assurance Committee for review and evaluate need for further action times one.	
F 814 SS=E	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation, it was determined that the facility failed to ensure that garbage was properly maintained in covered receptacles and that the garbage disposal area was free of debris, to prevent infestation. Findings include: During an inspection of the garbage disposal area on 2/26/18 at 10 AM, the dumpster for overflow trash was observed with the lid over the receptacle, not completely covering it, as a bag of garbage hanging over the dumpster prevented the lid from closing. The ground immediately in front of and on one side of the dumpster was also observed to be littered with debris. Findings were reviewed with E1 (NHA) and E2 (DON) on 3/1/18 at 5:15 PM during the Exit Conference. The facility failed to ensure that garbage was properly maintained and that the garbage area was free of debris.	F 814	It is the intent of the facility to dispose of garbage and refuse properly. A. No residents were identified by this practice. The dumpster was emptied debris was removed from the immediate area on 3/15/18. B. Current residents have the potential of being affected by this practice. c. The Administrator or designee will educate the maintenance, housekeeping and dietary staff regarding the need of keeping the dumpster from overflowing, and keeping the surrounding area free from debris. D. The maintenance director or designee will audit the dumpster and the surrounding area to evaluate that the dumpster is not overflowing and that the	4/25/18

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F 814	Continued From page 75	F 814	area surrounding is free from debris. Audits will be completed daily until consistently reaching 100% success over three consecutive evaluations then three times then weekly until reaching 100% success over three consecutive evaluations then monthly until reaching 100%. Results of these audits will be forwarded to the Quality Assurance Committee for review and evaluate need for further action times one.	
F 880 SS=D	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, 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;	F 880		4/25/18

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F 880	Continued From page 76 §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 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.	F 880		

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F 880	Continued From page 77 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 and interviews, it was determined that the facility failed to ensure proper infection control techniques during medication administration for two (R65 and R161) out of 55 sampled residents. In addition, the facility failed to ensure the soiled linen room maintained negative air pressure. Findings include: 1. During medication administration on 2/23/18 at 9 AM, E12 (LPN Supervisor) was observed administering medications to a resident and then E12 immediately began preparing medications for another resident, R161, without hand sanitizing or washing her hands in between. After R161 received the medications, E12 did not hand sanitize or wash her hands prior to beginning to prepare the next resident's (R65) medications. 2. On 2/23/18 at 9:08 AM, E12 was preparing R65's medications and R161 came out of her room stating that her Clonidine patch fell off. E12, without gloves, hand sanitizing, or washing her hands put R161's Clonidine patch back on her upper back. E12 did not hand sanitize or wash her hands afterwards and returned to preparing R65's medications. During an interview with E12 on 2/23/18 at 9:20 AM, the findings were reviewed and confirmed. The facility failed to ensure proper infection control techniques during medication administration.	F 880	It is the intent of the facility to ensure that an infection prevention and control program has been established that is designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. A. R# 65 and R#161 were not negatively impacted by this process. The door between the soiled linen room and the clean linen room was closed. B. Current residents have the potential of being impacted by this practice. C. The Staff Development Nurse or designee will educate licensed nurses regarding hand hygiene while administering medications. The Housekeeping Director or designee will educate laundry staff regarding keeping the door closed between the soiled linen room and the clean linen room. D. The Unit Manager or designee will complete medication pass observations to evaluate hand hygiene. The Housekeeping Supervisor or designee will audit the laundry department to ensure that the door between the clean linen room and the soiled linen room is kept	

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F 880	Continued From page 78 During the Exit Conference on 3/1/18 at approximately 5:15 PM, findings were reviewed with E1 (NHA) and E2 (DON). 3. Observation of the laundry room on 3/1/18 at 8:50 AM revealed that the door between the soiled linen room and the clean linen room was propped open. During an interview on 3/1/18 at 9:15 AM, E16 (housekeeping aide) stated that the door between the soiled linen room and the clean linen room was usually open because "it's hot folding clothes in the room with the dryers." During an interview on 3/1/18 at 9:25 AM, E17 (laundry/housekeeping supervisor) stated the negative air pressure for the soiled linen room does not work if the door between the soiled linen room and the clean linen room was open. E17 closed the door between the two rooms, and demonstrated working negative air pressure in the soiled linen room. The facility failed to ensure the soiled linen room maintained negative air pressure by keeping the door between the soiled linen room and the clean linen room closed. Findings were reviewed with E1 (NHA) and E2 (DON) on 3/1/18 at approximately 1:30 PM.	F 880	closed. Audits will be completed daily until consistently reaching 100% success over three consecutive evaluations then three times then weekly until reaching 100% success over three consecutive evaluations then monthly until reaching 100%. Results of these audits will be forwarded to the Quality Assurance Committee for review and evaluate need for further action times one.	

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

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

APR 09 2018

STATE SURVEY REPORT

NAME OF FACILITY: ManorCare Health Services – Pike Creek **DATE SURVEY COMPLETED: 3/1/18**

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced annual and complaint survey was conducted at this facility from February 20, 2018 to March 1, 2018. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census the first day of the survey was 164. The survey sample size was 55. Additionally an Emergency Preparedness survey was also conducted during this some time period.		
3201	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.0	**Scope**		
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** This requirement is not met as evidenced by: Cross Refer to the CMS 2567-L survey completed March 1, 2018: F550, F577, F578, F609, F623, F625, F641, F658, F679, F684, F688, F725, F760, F773, F804, F812, F814, F880.	Please Refer to Federal Plan of Correction in CMS Aspen System.	4/15/18

Provider's Signature K Perrone Title NHA Date 4/9/18