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 _____	C 09/10/2024

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PIKE CREEK NURSING & REHABILITATION CENTER	5651 LIMESTONE ROAD WILMINGTON, DE 19808

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F 760	Continued From page 85 administered R322's medications scheduled at 8:00 AM. 7/6/24 at 3:40 PM - A nurse's note by E44 (House Supervisor) documented, "Patient was given medications that were prescribed for another resident. Patient was assessed; found to have an irregular pulse and low blood pressure. NP (Nurse Practitioner) and responsible party notify. Received order to send patient to ER (emergency room) for evaluation." 7/6/24 at 4:00 PM - A transfer to hospital summary note by E43 (RN) documented, "Patient received medications scheduled for patient [R144]... Patient unremarkable in appearance, denies pain, symptoms, vitals 88/58 BP (blood pressure), HR (heart rate) 94, pulse ox 98% on baseline 4L (liters), skin warm, pink, no signs of distress, patient states 'I feel fine' 'I don't want to go to [name of hospital]'. Supervisor contacted, On-call MD (Medical Doctor) and RN contacted, ADON contacted, patient, [name of F3, family member]... contacted, EMS (Emergency Medical Services) summoned to take patient to [name] ER." 7/6/24 at 4:21 PM - The hospital record documented the following: "... presents to the ED (emergency department) with hypoglycemia (low blood sugar) and hypotension (low blood pressure) after receiving the wrong medications at his rehab facility... EMS was activated. Upon EMS arrival, patient was found to be hypoglycemic in the 50s and oral glucose was given. Upon arrival here in the ED, patient was found to be hypotensive and hypoglycemic... likely secondary to the diabetic medications and antihypertensives he was given. Patient does not	F 760		

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F 760	Continued From page 86 have a history of diabetes and is no longer on antihypertensives due to being hypotensive at baseline. Given that the patient was given glipizide (diabetic medication), he will most likely have persistent drops in his glucose. He will likely require repeated boluses (large doses) of D50 (dextrose sugar in water solution) and may still need to be started on a dextrose (sugar) drip. Ultimately, patient will require frequent glucose (sugar) checks and will need an ICU admission for management...". 7/8/24 at 4:45 PM - Two days later, the facility reported the 7/6/24 incident to the State Agency as "Resident [name of R322]... received another resident's medications... Resident became hypotensive and was transferred to hospital for evaluation. Investigation in progress. All licensed nurses to be educated on medication administration." The facility's investigation included the following statements: -"E43's (RN) written statement included:... date of incident: 7/6/24; time of incident: 14:00 (2:00 PM); "I passed medications, realized error, alerted MD and Supervisor... Name(s) of staff member(s) involved: [name of E43 (RN)], E44 (House Supervisor)... Please identify any statements made by resident: 'I feel fine.' Identify all people you spoke with regarding the incident and describe what was said (ie staff, family of resident, etc.): on call Dr (doctor)... [name of E44], EMS, pt (patient), [title of F3, family member], [title of F4, family member]. Identify any documentation you completed related to the incident: Incident... Please provide any additional information: n/a (not applicable). Date the statement completed: (incorrect date). Time	F 760		

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F 760	Continued From page 87 statement completed: 1101 (11:01 AM)." -E45's (COTA) written statement (undated/untimed) included: "... Around 12:30 PM this writer went to attempt to perform OT (occupational therapy) services with resident. [Title of F3] present. Resident stated 'no' and 'I don't want to' multiple times so this writer came back around 2:00 PM to attempt again. Upon returning to room, this writer was informed by resident's [title of F3] that at around 12:00 PM this day, patient was given another resident's dose of medication. The resident stated 'I feel fine.' At this time, nurse was on phone with family member [title of F4] and the charge nurse had come into room. Vitals were taken on resident by nurse and charge nurse made the decision to send the resident to the hospital. Resident continued to say 'I feel fine, I don't want to go to hospital.' This writer and resident's [title of F3] explained the situation in full to resident and he agreed to go. This writer assisted resident in putting on pants, socks, and shoes prior to ambulance getting to facility. This writer assisted resident in sitting up at the edge of the bed and when paramedics arrived, assisted in transfer to stretcher... Resident didn't say anymore, however [title of F3] was upset about incident...". 7/8/24 (date initiated) - The facility's Performance Improvement Plan documented that E43 (RN) had a review of his job performance which indicated a need to improve on Medication Administration. This document was signed and dated... by both E43 (RN) and E3 (ADON). 7/8/24 - The facility's Employee Corrective Action documented, "On 7/6/24 [name of E43, RN] administered Patient... medications to Patient...	F 760		

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F 760	Continued From page 88 resulting in Patient... requiring hospitalization... [name of E43] is being suspended pending investigation." This document was signed and dated 7/8/24 by E43 (RN), E3 (ADON) and E1 (NHA). 7/10/24 at 4:38 PM - R322's hospital discharge summary documented, "... Patient had blood pressure as low as 69/55... Patient had point-of-care glucose of 50 requiring ampules (sealed glass vessel holding solution to be injected) of D50. In the emergency department patient was started on norepinephrine infusion (intravenous infusion to raise blood pressure in patients with severe, acute hypotension). The patient was admitted to the ICU for shock (critical medical condition) related to iatrogenic (illness caused by treatment) antihypertensive medication, hypoglycemia (low blood sugar) related to glipizide (diabetic medication) ingestion. He was treated supportively with vasopressors (medications that increase blood pressure in emergency situations), fluids, and stress dose steroids (medication that aids in preventing complications) for his hypotension and shock. For his hypoglycemia, he was given dextrose infusions and ampules as needed. He was also started on octreotride drip (infusion medication to inhibit insulin release from the pancreas) for his sulfonylurea overdose (prolonged low blood sugar). With these interventions, his sugars normalized, and he was weaned off vasopressors by the morning of 7/07. Stress dose steroids have also been discontinued... Patient is now maintaining his blood pressure and blood sugar without supportive medications...". 7/11/24 - The facility submitted the following five day follow-up investigation to the State Agency:	F 760		

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F 760	Continued From page 89 -root cause analysis:... Failure to dual identify the resident prior to medication administration resulted in the error. The resident's picture was not available in PointClickCare (PCC/electronic medical record) at the time of the error. -result of investigation: Staff member acknowledges medication error, stating 'I don't remember, in my head I thought I knew who the patient was. We don't bring the laptop in the room. I knew... who was in the room and who he was, but I had them confused, it turned out. On the MAR they were side by side, and I think I just read the first two letters... and got them confused... You stated his family was there, did you check with them on his name? No I didn't. To me, there was no question. I'd done that group of patients before. I just went too fast. I didn't check enough of my fail-safes. What fail-safes should you have checked? I could have verbally asked. To me, it was just a simple mistake on my part. At what point did you realize you had given the medications to the wrong resident? And how? I think it was about an hour from then, when I went to pass the medications to the second gentlemen (sic) and realized I had confused them before because the medications were different. All licensed nurses were reeducated on the rights of medication administration and medication competencies were performed. 100% audit was completed to confirm all residents have a picture in PCC or a bracelet ID (identification). Resident condition is unknown at this time as he did not return to the facility. -system changes: Resident's are to be issued name bracelets until photos are uploaded into PCC." Review of the facility's education after this incident by the Surveyor revealed that all licensed	F 760		

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F 760	Continued From page 90 nurses were not educated nor competencies performed on medication administration. 8/8/24 at 11:58 AM - During an interview, E44 (House Supervisor) stated that she was completing a new admission on the second floor when E43 (RN) came up to ask her how to complete a medication occurrence. E44 stated that she explained the process and the nurse seemed very nonchalant (appearing relaxed and calm). E44 stated that she stopped working on the new admission because she thought she needed to follow-up on exactly what happened. E44 stated that when she arrived on the first floor, E43 was on the phone talking to the NP on-call and family. E44 stated that he [E43] told me at almost 2 PM. E44 stated that she reviewed the medications that were given which included 3 medications for blood pressure. E44 stated that she assessed the resident - blood pressure was low, heart rate irregular, resident has to go out. E44 stated that she called the doctor and received an order to send the resident out to the ER. 8/8/24 at 12:15 PM - On this date/time, the Surveyor placed a call and left a voicemail for E43 (RN) to return the call. As of 8/12/24 at 3:30 PM, no return call was received by the Surveyor. 8/12/24 at 9:44 AM - During an interview, E45 (COTA) stated that she entered the resident's room earlier on 7/6/24 and R322 declined therapy. E45 stated that when she went back to R322's room, she was present when the nurse, E43, came in and told the resident, with [F3, family member] present, that he gave him someone else's medications. The [title of F3] was upset and immediately called [title of F4] and [title	F 760		

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F 760	Continued From page 91 of F4] was asking the nurse what medications were given. E45 stated that she was there when the charge nurse came in and said he was going to the ER. E45 stated that she assisted the resident with putting on his pants. While the facility documented the root cause analysis as R322's picture was not uploaded to PCC as an identifier, the facility failed to identify and address the following additional issues in their investigation: - identify the exact time E43 (RN) administered the wrong medications to R322. It was unclear in the facility's investigation exactly what time R322 was administered the wrong medications that were scheduled for 8:00 AM. Per E45's (COTA) written statement, [title of F3] told her that around 12 PM the resident was given another resident's dose of medications, four hours after the scheduled time. -failed to immediately suspend and/or remove E43 (RN) from administering medications to residents pending the facility's investigation. E43 continued to administer medications on 7/7/24 entire day shift, and on 7/8/24 morning day shift then was interviewed and suspended. E43 administered morning medications on 7/8/24 to R144. -failed to immediately report the significant medication error requiring emergent care to the State Agency within 8 hours, per State requirement. -failed to provide the Surveyor, as requested, with evidence of E43's (RN) education and medication competency before returning to work on 7/14/24, 7/15/24, 7/17/24, 7/18/24, 7/19/24, 7/20/24, 7/21/24, 7/22/24, 7/23/24, 7/24/24, 7/25/24, 7/26/24, 7/27/24. -failed to perform an audit of the other resident's	F 760		

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F 760	Continued From page 92 on E43's assignment on 7/6/24 for any medication errors, which included timeliness of administration, and document in the facility's investigation. 8/12/24 at approximately 11:30 AM - During a combined interview with E1 (NHA), E2 (DON), E3 (ADON) and E10 (VPO) to discuss R322's incident, the Surveyor asked about the education and competency of E43 (RN) as it was not included in the documentation provided. E3 (ADON) stated that it was included and immediately reviewed the red folder with the documentation that provided to the Surveyor. E3 (ADON) confirmed it was not there. No further documentation was provided to the Surveyor. The Surveyor also asked about E43's current status in the facility. E1 (NHA) stated that E43 resigned about two weeks ago. No reason provided. 8/22/24 at 9:40 AM - During a follow-up interview, E44 (House Supervisor) confirmed that she notified E36 (UM/on call nurse) and E3 (ADON) on 7/6/24 between 2 PM - 4 PM of the medication error and transfer to hospital. 8/22/24 at 12:12 PM - During an interview, F4 (R322's family member) stated that F3 (R322's family member) called me and told me that R322 received the wrong medications. F4 stated that [F3] left the facility to go get ice cream and came back and all hell broke loose. F4 stated that the nurse (E43, RN) reviewed all of the medications and what they were for over the phone and he said "Oh we are going to monitor his vitals. He seemed calm and said - all well this happens. He was really rude." F4 said, "He could have died. And he was a DNR (do not resuscitate) and if he died we would never have known."	F 760		

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F 760	Continued From page 93 8/22/24 at 2:18 PM - During an interview, F3 (R322's family member) stated that she kept notes and reviewed them with the Surveyor. F3 stated she arrived at the facility at 10:40 AM and R322 was very alert. F3 stated that F3 stated that he had not been eating a lot. F3 stated that around 12:05 PM, the nurse [E43] brought him his meds and I asked the nurse what medications are being given. [E43] replied just the normal daily and Tylenol. F3 stated that the nurse confirmed that he didn't have narcotics and that he knew that [F4] did not want the resident to have any narcotics. At 12:15 PM, lunch was served and [R322] started to ignore me and did not want to eat. E45 (COTA) came in and [R322] was out of it as he didn't want to eat or do anything. At 12:20 PM, [R322] put his bed back. At 12:30 PM, I texted [another family member] that I think they gave him something because he was out of it. At 12:48 PM and 12:50 PM, [R322] kept taking off his nasal cannula off his nose. [R322] slept for little while and woke up at 1:45 PM and asked for ice cream. F3 said that I thought I would give him anything he would eat. F3 said she went to the grocery store at 1:45 PM and returned at 2:15 PM. The supervising nurse told me that they had given [R322] the wrong medications. I called [F4]. E45 (COTA) came back and I told her what happened. F3 stated that the supervising nurse checked vital signs, notified the doctor and called 911. The other nurse [E43] was on the phone with [F4] because [F4] wanted to know what medications were given. F3 stated that R322 ate some ice cream and said he was fine. F3 stated that the EMTs asked if the resident was a DNR and I knew he was a DNR. F3 stated that the nurse [E43] seemed very calm and it didn't seem like a big deal as he kept asking the	F 760		

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F 760	Continued From page 94 resident, "How are you buddy?" 8/23/24 at 2:08 PM - During a meeting with facility management, the Survey Team notified E1 (NHA), E2 (DON) and E59 (incoming DON) of an Immediate Jeopardy for R322's significant medication error that occurred on 7/6/24. 8/23/24 at 7:12 PM - E1 (NHA) submitted a signed, dated and timed written abatement plan to the State Agency. The facility's abatement included: -Licensed nurses will be assigned education "Avoiding Common Medication Errors" on Relias platform to complete in a proctored group setting at the Center or individually independently if not on schedule ... Those completing it individually and independently will be educated once they are scheduled by a nurse manager on the specifics of the reasons/need for the education. Licensed nurses will complete this education and pass the final exam associated with it. Licensed nurses will complete a return demonstration of the education with a Nurse Manager utilizing a real-life medication administration for one resident. The nurse will be required to demonstrate review of the Rights of Medication Administration prior to administering the medication and passing the return-demonstration. -Administration team was notified of incident on 8/23/24 @ (at) 5:00 p.m. to be aware of the situation as leaders of the Facility. -Each resident's picture is uploaded into PCC unless refused, and those that refuse have all agreed to wear a wrist identification band. As of 8/23/24 all photos are up to date and complete for all residents admitted within the last 24 hours. -At time of education, Nurses will be educated on	F 760		

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F 760	Continued From page 95 timely reporting of errors to supervisors and physicians ... Date of abatement 8/26/24 @ 11:59 p.m." 8/26/24 at 10:35 AM - During an interview, E36 (UM/on call nurse) stated that she was on the phone with E44 (House Supervisor) regarding another issue when she was told about R322's medication error. E36 stated that E44 was still upstairs and did not know the details about the med error yet. E36 stated that she found out later that day that R322 was sent to the hospital. E36 confirmed that she called E3 (ADON) on 7/6/24 regarding the medication error. 8/26/24 at 2:08 PM - During an interview, E2 (DON) stated that E34 (HR) was the Manager on Duty (MOD) on 7/6/24. E2 confirmed that MOD's do not report any incidents to the State Agency, only the DON and ADON. E2 confirmed E3 (ADON) was back up as she was off that weekend. Based on record review of the facility's abatement plan which included nursing staff education, testing, signed attestation and observation of medication administration, follow-up interviews with nursing staff, review of new admissions records for pictures or identification bracelets and no further medication error incidents, the facility's IJ was abated on 8/26/24 at 11:59 PM. 2. Cross refer to F726, example 3 Review of R48 and R95's clinical records revealed: For R48: 2/1/23 - R48's census record documented her	F 760		

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F 760	Continued From page 96 room and bed as XXX, B bed. 8/18/24 - R48's August 2024 eMAR revealed the following scheduled medications: - Ambien 5 MG, one tablet, for insomnia at 8 PM; - Tramadol 25 MG, one tablet, for pain at 8 PM; and - Xanax 0.5 MG, one tablet, for anxiety disorder at 9 PM. E55 (LPN) signed off the above medications as administered on the eMAR. In addition, E55 documented in the medication cart's controlled substance tracking book that the above three medications were signed out by E55 between 7:05 PM through 7:10 PM. For R95: 2/21/24 - R95's census record documented her room and bed as XXX, A bed. 5/22/24 - The quarterly MDS assessment documented that R95 had a BIMS of 7 (cognitive impairment). 8/18/24 at 8:00 PM - The facility's incident report documented, "[Name of R95] received medications that were for her roommate: Tramadol 25 mg, Alprazolam 0.5 mg and Ambien 5 mg. Patient unable to give description." 8/18/24 at 9:37 PM - The facility reported the medication error to the State Agency and stated that "New orders to monitor vitals and neuro checks. Nurse has been suspended pending investigation." 8/19/24 (untimed) - A documented telephone interview between E2 (DON) and E55 (LPN) revealed: "Tell me about when you were giving	F 760		

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medications in room XXX at about 7:00 pm. I confirmed correct name and dosage to computer for the medications for [name of R48]. I took out the 3 meds, Tramadol, Ambien and Alprazolam. Why did you take only the 3 out and not her other scheduled medications? I was going to get the others, but I got sidetracked by the conversation at the nurse's station. Why didn't you also pull out the other scheduled 8:00 pm medications? I like to get the narcotics out and sign them out of the book. I usually get the narcotics then the other meds, but I walked away and when I came back I did not get the other meds out. My relief was there, and they were talking at the nurse's station, and I wanted to confirm with her (nurse relieving) that she was ready to report over, so I could start my documentation. I was up there for a while because I did not want to interrupt anyone's conversation. After I talked to her, I got the medications off the cart and I went into the room to the wrong patient, I got completely sidetracked. Was the nurse relieving you at the nurse's station? Yes, I was pretty sure it was, I wanted to confirm with her. There were other staff up there, I am not sure who everyone is (sic). I had a lot going on, the patient next door had some redness on her foot up to her thigh, her foot and ankle were swollen, I had a lot of stuff going on in my head. I went back to nursing cart, I already had the medication out in a cup, (Tramadol, Ambien, and Alprazolam) it was already prepared and I went to room XXX: (sic) I mistakenly went to the wrong bed, I realized when I went to chart, I gave the meds to A bed. [name of R95] How did you identify the patient when you went into the room? I looked at her and said I had her medications; I did not ask her name. Did you look at her picture in PCC? I looked at the picture and I was in the right room. When I went back from the nurse's

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station to get the medication off the cart I went to the wrong bed. Were you in the room prior to this time, did either of these residents get medication on the first med pass? Yes, I believe they got the medications that were due around 4:00 p.m. (review of the MAR determined that each resident did receive 4:00 pm medications that were signed out appropriately). 7:30 came and I started on the 8:00 o'clock meds. Did you identify those patients in the room? There was no distraction going on so I as (sic) able to focus. Do you remember how you identified the patients the first time you were in the (sic) there to give medications at 4:00 pm? Yes, I asked their names and I identified them by their picture. How did you ask them their name? I said, 'Hey [name of R95], or [name of R48]', before giving each of them their medications, they said yes that's me or they said yes. What time did you give the medications? It was about 7:30 when I gave the medication. It took about 20 minutes to give report then I went to do my documentation, then I realized I made a mistake, I told the nurse who took over, I got a hold of E60 (RN Supervisor) then E36 (UM/on call nurse) and then [name of E36] called [E2] (Director of Nursing). I came out of the room to give nurse, [name of E44], report at the cart, report and narcotic count were completed. Sat down at the computer to chart medication, I looked and saw the room number I realized it was XXXB bed's meds that I gave to XXXA. I immediately contacted nursing supervisor DON- nurse on call - and the NP. NP gave orders for vitals and neuro checks, and alert charting. [Title and name of R95's resident representative] was contacted 3x to no avail. A voicemail left with call back for contacting."

Undated/untimed - A documented telephone interview between E2 (DON) and E44 (on-coming

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F 760	Continued From page 99 Nurse) revealed: "I relieved the nurse for the patient. She realized her mistake and told me; the supervisor was told. We checked the patient, and she was fine. Everyone was notified. The patient was monitored when I was there, she was fine." 8/23/24 - The facility submitted a five day follow up to the State Agency, which included: - Root cause analysis: "The nurse did not follow proper procedure for medication administration causing the medication error." - Result of Investigation: "... the resident remained at the facility, vitals and neuro checks remained stable and there were no adverse outcomes in the patient's condition. The nurse had received the 10 rights of medication administration education during the new hire orientation which took place between June 24 and June 28, 2024. The nurse remained suspended pending investigation. She will be returned to the facility after education, coaching/counseling and a medication pass observation has been completed... The other resident's medication administration records on the nurse's assignment were reviewed with no discrepancies noted, alert and oriented residents on the nurses' assignment were interviewed and asked if they had any issues with their medications given on 3-11 (PM) shift on 8/18/24 and there were no issues." 8/22/24 at 9:40 AM - During an interview, E44 (on-coming nurse) confirmed that she worked 7 PM to 11 PM on 8/18/24. E44 stated that she relieved E55 (LPN) and was made aware of the medication error as E55 immediately self-reported and was upset about it. E44 stated that she was familiar with the resident and monitored R95 closely. E44 stated that the	F 760		

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F 760	Continued From page 100 resident did not have a negative outcome. 8/23/24 at 12:35 PM - Observation of R95 in her room revealed that she was alert and was able to tell this Surveyor her name when asked. The facility failed to ensure R95 remained free of significant medication error. 3. Review of R22's clinical records revealed: 8/2/23 - R22 was admitted to the facility with diagnoses including diabetes and heart disease. 10/26/23 - R22's care plans documented, "The resident is at risk for complications and blood glucose due to diagnosis of diabetes ...and insulin use." 5/7/24 - R22's quarterly MDS assessment documented a BIMS score of 15 (indicating sufficient judgement to manage every day events.) 5/31/24 - R22's Medication Administration Record (MAR) documented, "Humalog Kwik Pen-injector 100 Unit/ML (fast acting insulin), inject per sliding scale before meals - if 0 - 100 = No insulin; 101 - 150 = 2 units insulin; 151 - 200 = 4 units insulin; 201 - 250 = 6 units insulin; 251 - 300 = 8 units insulin." Humalog Kwik Pen manufacturer (Eli Lilly and Company, 9/1/23) instructions, "Take (insulin) within 15 minutes before or right after a meal." 8/1/24 7:30 AM - R22's MAR documented a blood glucose of 124 and received two (2) units of fast acting insulin. R22 was observed receiving a	F 760		

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F 760	Continued From page 101 meal tray at 9:45 AM (2 hours and 30 minutes later.) 8/1/24 11:30 AM - R22's MAR documented a blood glucose of 224 and received six (6) units of fast acting insulin. R22 was observed receiving a meal tray at 1:45 PM (2 hours and 45 minutes later.) 8/2/24 7:30 AM - R22's MAR documented a blood glucose of 295 and received 8 (eight) units of fast acting insulin. R22 was observed receiving a meal tray at 9:45 AM (2 hours and 30 minutes later.) During an interview, R22 stated, "I usually get my insulin when they (nurses) check my blood sugar." 8/2/24 10:00 AM - During an interview E42 (LPN) stated, "I gave the residents their insulin when I checked their blood sugars." 4. Review of R33's clinical records revealed: 7/1/23 - R33 was admitted to the facility with diagnoses including diabetes and long -term use of insulin. 2/1/24 - R33's MAR documented, "Humalog Kwik Pen 100 Unit/ML (fast acting insulin) inject as per sliding scale before meals: 101 - 150 = 2units; 151 - 200 = 4units; 201 - 250 = 6units; 251 - 300 = 8units; 301 - 350 = 10units; 351 - 400 = 12units ...." 7/4/24 - R33's care plan documented, " ...At risk for complications and blood glucose fluctuations related to diagnosis of diabetes mellitus with insulin use ...administer insulin as ordered."	F 760		

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F 760	Continued From page 102 7/8/24 - R33's annual MDS assessment documented a BIMS score of 15 (indicating sufficient judgement to manage every day events.) 8/1/24 7:30 AM - R33's MAR documented a blood glucose of 163. R33 received four (4) units of fasting acting insulin. R33 was observed receiving a meal tray at 9:45 AM (2 hours and 15 minutes later.) 8/1/24 11:51 AM - R33's MAR documented a blood glucose of 233. R33 received 6 units (six) of fast acting insulin. R33 was observed receiving a meal tray at 1:45 PM (1 hour and 51 minutes later.) 8/2/24 7:32 AM - R33's MAR documented a blood glucose of 161. R33 received 4 (four) units of fast acting insulin. R33 was observed receiving a meal tray at 9:30 AM (2 hours later.) During an interview, R33 stated, "I get my insulin when I get my blood sugar checked." 8/2/24 10:00 AM - During an interview E42 (LPN) stated, "I gave the residents their insulin when I checked their blood sugars." 8/12/24 2:15 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON), E10 (VPO) and a State of DE Ombudsman (via telephone).	F 760		
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care.	F 791		11/11/24

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F 791	Continued From page 103 §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by:	F 791		

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F 791	Continued From page 104 Based on observation, interview, and record review, it was determined that for one (R109) out of two residents reviewed for dental care, the facility failed to provide routine dental services to meet R109's needs. Findings include: 9/29/23 - R109 was admitted to the facility with diagnoses including cerebral palsy and bipolar disorder. 7/8/24 - R109's quarterly MDS assessment documented a BIMS score of 14, indicating a cognitively intact status. 7/8/24 - R109's quarterly MDS assessment documented, "Mouth or facial pain, discomfort or difficulty with chewing? "Yes". 7/29/24 10:28 AM - R109 was observed with chipped and broken front teeth. During an interview, R109 stated, "I don't have pain right now, but I am worried my teeth are getting worse because they are already broken." The surveyor asked R109 if the facility offered him to see a dentist. R109 stated, "I don't remember if I was offered to see the dentist." 8/2/24 12:40 PM - A review of R109's clinical records lacked evidence of a dental consult for his complaint of pain on 7/8/24. During an interview, E3 (ADON) stated, "[R109] will be added to the dental list." The facility failed to provide routine dental services for R109 for complaints of mouth pain. 8/12/24 2:15 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON), E10 (VPO) and a State of DE Ombudsman (via telephone).	F 791	F791 1. R109 no longer resides in the facility. 2. All residents experiencing mouth pain have the potential to be affected by this practice. DON/Designee completed a 100% audit of all residents who reflect dental pain per their last MDS assessment to verify dental consultation and appropriate interventions. Those residents identified with noted dental pain and no dental consult will be communicated to the provider for follow-up. 3. It was determined that the root cause was the facility staff failed to ensure routine dental services were provided due to failure to provide a secondary follow up on request due to initial resident refusal. The DON/Designee will in-service licensed nurses on ensuring that routine dental services are offered and provided to residents as well as ensuring consults are followed up on should the resident refuse initial consult. 4. The DON/Designee will audit all residents that trigger for dental issues per the MDS to verify dental consult and appropriate interventions are in place as ordered weekly x 4 weeks until 100%, and then monthly x 3 until 100%. All audits will be submitted to the QAA committee monthly. The results of the audits will be reported X 4 months. The QAA committee will determine what, if any, additional intervention is needed at the end of the 4 months. 5. Date of completion: 11.11.2024	

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F 800 SS=E	Provided Diet Meets Needs of Each Resident CFR(s): 483.60 §483.60 Food and nutrition services. The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. This REQUIREMENT is not met as evidenced by: Based on random observation and interview, it was determined that the facility failed to provide food to residents taking into consideration their preferences. Findings include: 8/1/24 - Breakfast and lunch observation for roommates R119 and R126 revealed that the dining tickets on both resident's trays had missing information: -R119 did not have Tray Notes, Instructions and Dislikes section populated. Additionally, the middle section of the dining ticket that would have the contents of the delivered meal lacked a description of the meal contents; the section was blank. -R126 did not have information in the middle section of the breakfast and lunch dining ticket; that information would have included the contents of the delivered meal; the sections were blank. 8/1/24 2:00 PM - During a joint interview, R119 and R126 stated that the dining tickets have not had meal descriptions "for a while". Additionally, they both stated that they have not had meal menus presented to them for several months, so that they could select their meal preferences. "They have not been able to choose the food that	F 800	F-800 1. Upon discovery, tickets for residents noted were updated to include tray notes. 2. All residents have the potential to be affected. 3. Root cause determined to be deficiency in tray note/ticket software. This was corrected by Dietary Supervisor and all residents tray notes/tickets now include the items on the tray, the resident preferences, diets and allergies. Dietary department will meet with all residents to review preferences. Dietary Staff were educated by Dietary Supervisor on following tray tickets and providing alternative food options as appropriate. A dietary satisfaction survey will be conducted monthly for one year and brought to QAPI and Resident Council monthly to discuss areas for improvement. 4. Dietary Director will conduct an audit of tray tickets for all three meal daily to ensure tickets contain required information. Resident Satisfaction Surveys and discussions in Monthly Resident Council Meetings will be conducted and logged. The Administrator will review these audits and comments	11/11/24

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F 800	Continued From page 106 they want to eat" and they both expressed frustration over not knowing what food they are going to be served at each meal. 8/5/24 2:06 PM - During a joint interview E31 (Dietary Services Director) and E32 (Dietary Supervisor) stated that they are aware that the resident meal tickets are currently blank, "we are in the process of cleaning up the resident information in the computer for diet, tray notes, instructions, and dislikes. We were told to turn off (in the computer) the menu selection feature until that task was completed. We expect to turn the menu selection feature back on by the end of this week and the meal information should then be present." Additionally, the person who was tasked to present menus to residents and help residents to complete the menus, and them collect them to bring back to the kitchen recently returned to work after having been off for several weeks". The facility's dining services failed to have a process for residents to be involved in their menu/food selections as evidenced by facility residents not being given choices for their menu/food selections in advance of their meal delivery. 8/12/24 2:15 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON), E10 (VPO) and a State of DE Ombudsman (via telephone).	F 800	monthly. The results of these audits will be reviewed with the Quality Assurance and Assessment Committee (QAA). The committee will determine the need for additional audits. The results will be reviewed at the QAA meeting monthly x 3 months. 5. Date of compliance: 11.11.2024	
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp 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	F 804		11/11/24

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F 804	Continued From page 107 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 observation and interview it was determined that for four (R21, R90, R119 and R172) randomly observed residents during dining observations, the facility failed to ensure food was served was palatable and at appetizing temperatures. Findings include: 1. Dining observation on 7/29/24 on the first floor unit right revealed: - 12:09 PM - Meal delivery cart containing lunch trays was delivered to the hallway. - 12:18 PM - R172's lunch tray taken to room was delivered to the bedside table by E39 (CNA) who then left the room with the residents breakfast tray and did not return. - 1:29 PM - R172 was repositioned in bed and offered assistance to eat lunch by E37 (CNA). The gravy on the mashed potatoes appeared firm and shiny. There was no visible steam. R172 began to feed himself with cueing, frowned and stopped eating after a few bites and shook head "no". - 1:38 PM - E40 (DA) arrived to obtain food temperatures for R172's tray; crab cake 89.8 degrees, carrots mashed 91.3 degree's pot 93.1 degree's. During this time E37(CNA) confirmed that R172 meal was cold and stated, "his ice cream is melted". During an interview on 7/29/24 at 1:54 PM, E38 (RN) confirmed that R172 should have received a replacement tray after 30 minutes and went to	F 804	F-804 1 Upon discovery, residents noted were offered alternative options for meals. 2 All residents have the potential to be affected. 3 Root cause determined to be food warming equipment functionality, maintenance of temperature logs, and timely of meals to residents. Dietary Staff were educated by Administrator on maintaining temperature logs and immediately reporting any and all equipment found not working properly. Devices responsible for ensuring food is delivered at temperature were reviewed for functionality and repairs were ordered as necessary. Additional plate warming bases and lids were ordered to maintain a par level of required equipment. Facility Managers were educated on All Hands on Deck practice assist nursing staff with passing of meals to ensure temperatures are appropriate. A dietary satisfaction survey will be conducted monthly for one year and brought to QAPI and Resident Council monthly to discuss areas for improvement. 4 Dietary Director will conduct an audit of Food Temperatures for all three meal daily upon delivery to units and logged. Resident Satisfaction Surveys and discussions in Monthly Resident Council	

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F 804	Continued From page 108 retrieve another meal for the resident. 7/29/24 - Review of the kitchen's food temperature log for the lunch served to R172 indicate initial cooking temperatures as: entree/crabcake 181 degrees. starch/mashed potatoes 183 degrees. vegetable/carrots 167 degrees. 2. A review of R119's clinical record revealed: 12/29/22 - R119 was admitted to the facility. 8/1/24 9:10 AM - A random observation of R119's breakfast tray revealed that the tray did not include any packets of sugar. R119 stated that she likes to put sugar on her oatmeal and in her coffee. The finding was confirmed by E8 (CNA). 8/1/24 9:30 AM - A random observation of the facility second floor coffee cart revealed that the container that stored sugar did not have any sugar packets in it. The finding was confirmed by E8 (CNA). R119's food and drink were not palatable as evidenced by the facility not placing sugar packets on R119's 8/1/24 breakfast tray, or having sugar on the second floor coffee cart on 8/1/24 at the breakfast meal. 3. Review of R21's clinical records revealed: 2/11/23 - R21 was admitted to the facility with diagnoses including heart disease and diabetes. 5/14/24 - R21's quarterly MDS documented a BIMS score of 14, indicating a cognitively intact status. R21's diet orders documented, "Regular	F 804	Meetings will be conducted and logged. The Administrator will review these audits weekly. The results of these audits will be reviewed with the Quality Assurance and Assessment Committee (QAA). The committee will determine the need for additional audits. The results will be reviewed at the QAA meeting monthly x 3 months. 5 Date of completion: 11.11.2024	

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	085033	A. BUILDING _____ B. WING _____	C 09/10/2024

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F 804	Continued From page 109 diet." 7/30/24 9:45 AM - R21 was observed receiving her breakfast tray. R21 stated, "The food is horrible. See how cold it is?" The surveyor asked R21 to check the plate to see if it was warm. R21 touched the plate and stated, "It's cold." The meal ticket lacked documentation of the food that was served. 7/31/24 9:30 AM - R21 was observed eating her breakfast. R21 stated, "This food is cold. It is always cold." 7/31/24 1:00 PM - R21 was observed eating her lunch. R21 stated, "I don't know what this is but looks like some kind of pasta. It is barely warm." 8/1/24 9:30 AM - R21 was observed eating her breakfast. R21 stated, "This food is cold. I am tired of eating cold food every day." The surveyor asked R21 to touch the plate to check if it was warm, R21 touched the plate and stated, "It is cold." 4. Review of R90's clinical revealed: 6/15/24 - R90 was admitted to the facility with diagnoses including heart disease and high blood pressure. 6/27/24 - R90's admission MDS assessment documented a BIMS of 15, indicating a cognitively intact mental status. R90's diet order documented, "Heart Healthy Diet, Regular Texture." 7/29/24 10:50 AM - R90 was observed eating her breakfast. R90 stated, "The food is cold almost all	F 804		

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F 804	Continued From page 110 of the time." 7/30/24 1:30 PM - R90 was observed eating her lunch. R90 stated, "This food is cold, I don't know what I am eating." The surveyor asked R90 to touch the food plate to check if it was warm. R90 touched the plate, and stated, "It is cold." 7/31/24 1:07 PM - R90 was observed eating her lunch. R20 stated, "I guess it's supposed to chicken parmesan. It would probably be good if it was warm." 8/12/24 2:15 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON), E10 (VPO) and a State of DE Ombudsman (via telephone).	F 804		
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that for one (R126) out of four sampled residents reviewed for food, the facility failed to provide food that accommodated R126's allergies. Findings include: Review of R126's clinical record revealed:	F 806	F-806 1. Upon discovery, R126 was assessed for adverse affects and none were noted. R126 was provided with appropriate sweetener. 2. All residents with food allergies have the potential to be affected.	11/11/24

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F 806	Continued From page 111 3/6/23 - R126 was admitted to the facility. 2/13/24 - R126's allergy list was updated to include aspartame, an artificial sweetener for food and drinks. 8/1/24 9:15 AM - A random dining observation of R126's 's breakfast tray revealed the presence of two aspartame sweetener packets on the tray. R126's meal ticket on the breakfast tray documented an aspartame allergy. 8/1/24 9:20 AM - During an interview, E4 (CNA) confirmed the presence of two aspartame sweetener packets on R126's breakfast tray. 8/12/24 2:15 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON), E10 (VPO) and a State of DE Ombudsman (via telephone).	F 806	3. Root cause determined to be staff not following proper procedure to identify resident trays requiring allergy precautions. Dietary Staff were educated by Dietician on policy and procedure for following residents□ diets and allergies. Dietary slips with allergies or special diets will be either printed on different color paper or highlighted in color to assist kitchen staff on differentiating these tickets and call attention to extra precautions required on these tickets/trays. 4. An audit of meal trays for residents with allergies will be conducted daily by the kitchen manager or shift supervisor for one meal per day for 30 days to ensure compliance. The Administrator will review these audits weekly x 4 weeks until 100% consecutively and then monthly x 3 months until facility reaches 100% success. The results of these audits will be reviewed with the Quality Assurance and Assessment Committee (QAA). The committee will determine the need for additional audits. The results will be reviewed at the QAA meeting monthly x 3 months. 5. Date of completion: 11.11.2024	
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.	F 812		11/11/24

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F 812	Continued From page 112 (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that for three out of three units reviewed the facility failed to ensure food items in the nourishment refrigerators were labeled and dated. Findings include: Review of the facility's policy for Food bought in from outside sources policy and personal food storage, undated, indicated, "4. Food and beverages bought in from outside sources that require refrigeration or freezing will be labeled with with the patients/residents name and date. " Observation of facility's unit refrigerators revealed the following: 7/31/24 10:47 AM - First floor left wing unit refridgerator contained two unlabeled and undated food item's E36 (RN) and (UM) confirmed the finding. 7/31/24 12:43 PM - First floor right wing unit refridgerator contained four unlabeled and undated food item's E18 (LPN) and (UM)	F 812	F-812 1. No residents noted in 2567. 2. All residents have the potential to be affected. 3. Nursing staff will be educated on not storing personal items in Unit Refrigerators and on using the refrigerator in the staff lounge by SDC or designee. Review of unit refrigerators will be added to Unit Manager and Weekend Supervisor Rounds. 4. Refrigerators will be checked daily by Unit Managers and Weekend Supervisors for any personal items will be removed or discarded. Audits will be logged daily and brought to QAPI for three months for further review and recommendations. 5. Date of completion: 11.11.2024	

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F 812	Continued From page 113 confirmed the finding. 7/31/24 12:57 PM - Second floor unit refridgerator contained two unlabeled and undated items and the freezer contained two unlabeled and undated food items E9 (LPN) and (UM) confirmed the finding. 8/12/24 2:15 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON), E10 (VPO) and a State of DE Ombudsman (via telephone).	F 812		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-	F 842		11/11/24

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F 842	Continued From page 114	F 842		

(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic

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F 842	Continued From page 115 services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R119) out of fifty-four residents sampled in the survey, the facility did not maintain accurate medical records. Findings include: A review of R119's medical record revealed: 12/29/22 - R119 was admitted to the facility with multiple diagnoses, including left sided paralysis, left sided weakness resulting from a stroke, and anxiety. 12/30/22 - A medication order for clonazepam 2 milligrams for anxiety was ordered for R119 by E6 (Nurse Practitioner). A review of the clonazepam package insert revealed that the medication can cause drowsiness and dizziness. A review of the electronic medical record (Emr) revealed a 12/30/22 admission care plan that indicated that R119 was a fall risk due to a history of falls, impaired balance/poor coordination, gait (walking) unsteadiness and left sided weakness. 3/25/24 3:07 PM - An Emr progress note documented that R119 had a fall without injury at 2:34 PM. 3/25/24 6:42 PM-An Emr progress note documented that R119 had a fall without injury at 6:30 PM. 3/26/24 12:46 AM - An Emr progress note	F 842	F-842 1. R-119 still resides in the facility. Incident cited was 3/25/24. R-119 has not had any falls in the past 90 days. 2. All residents experiencing falls have the potential to be affected. A lookback audit of falls starting 8/16/24 was conducted by the RDCS to ensure all falls were compliant with including medications the resident takes as part of the investigation. 3. Licensed Nurses will be educated by the Staff Development Coordinator or designee on policy and procedure for investigating falls including but not limited to including the resident□s medications in the investigation. Root cause identified as staff knowledge and supervisor follow-up. Fall investigations will be reviewed at daily clinical meeting to ensure they are complete by the DON/ADON. 4. The Director of nursing or administrative nurse will audit falls weekly x 4 weeks until 100% consecutively and then monthly x 3 months until facility reaches 100% success with including medications in the fall investigations. The results of these audits will be reviewed with the Quality Assurance and Assessment Committee (QAA). The committee will determine the need for additional audits. The results will be reviewed at the QAA meeting monthly x 3 months. 5. Date of compliance : 11.11.2024	

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F 842	Continued From page 116 documented that R119 had a fall without injury at 12:40 AM. R119 was sent to the hospital for evaluation. 8/6/24 - A review of Emr Post Fall Investigations reports for the above falls revealed the following: -3/25/24 2:34 PM - A post fall investigation was completed in the Emr by a facility nurse. The investigation report incorrectly documented under the medication section that R119 was taking a narcotic, R119 was not taking a narcotic. The report documented that R119 was not taking antianxiety medication, R119 was taking antianxiety medication. Additionally, under the section titled clinical considerations, the report did not document that R119 had Hemiplegia/Hemiparesis and weakness, which were relevant clinical factors related to falls. -3/25/24 6:30 PM - A Post Fall investigation document was completed in the Emr by a facility nurse. The Fall report incorrectly documented under the medication section that R119 was not taking antianxiety medication, R119 was taking antianxiety medication. Additionally, under the section titled clinical considerations, the report did not document that R119 had Hemiplegia/Hemiparesis and weakness, which were relevant clinical factors related to falls. -3/26/24 12:40 AM - A Post Fall investigation document was completed in the Emr by a facility nurse. The Fall report incorrectly documented under the medication section that R119 was not taking antianxiety medication, R119 was taking antianxiety medication. Additionally, under the section titled clinical considerations, the report did not document that R119 had	F 842		

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F 842	Continued From page 117 Hemiplegia/Hemiparesis and weakness, which were relevant clinical factors related to falls. R119 had three falls between 3/25/24 2:30 PM and 3/26/24 12:40 AM. The facility Post Fall Investigation reports that were completed by facility nurses after each fall did not accurately document the medications that R119 was taking, or the medical diagnoses that R119 had, in order to accurately investigate the reasons for R119's three falls within twelve hours. 8/12/24 2:15 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON), E10 (VPO) and a State of DE Ombudsman (via telephone).	F 842		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but	F 867		11/11/24

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F 867	Continued From page 118 not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to	F 867		

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F 867	Continued From page 119 ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s)	F 867		

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F 867	Continued From page 120 functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on interview, review of the facility assessment and an identified deficient practice scoped as an Immediate Jeopardy during the survey, it was determined that the facility failed to conduct a quality assurance and performance improvement activity in response to R322's significant medication error and adverse event on 7/6/24. The facility failed to analyze the cause(s), implement preventive actions and mechanisms that included feedback and learning throughout the facility. Findings include: The facility's assessment, last updated 7/2024, revealed: "... 3.5 Staff Training/ education and competencies All staff members have a competency checklist upon hire that is completed during orientation to provide adequate care for our residents... Topics... Date Presented... Medication and Treatment administration... Orientation & Annually, and as needed...". Cross refer to F760, example 1 7/6/24 - Review of R322's clinical record and the	F 867	F-867 1. Resident 322 no longer resided in facility at time of Survey. 2. All residents have the potential to be affected. 3. Facility Leadership Team was educated by the Administrator on the QAPI Process for reviewing facility challenges, departmental projects, required action items relating to reportable events or surveys and any areas for quality and service improvement including Root Cause Analysis and SMART Goal setting and monthly reviewing. QAPI Meetings are held monthly. 4. Administrator and DON will review Departmental QAPI Reports monthly and QAPI Committee Meeting discussions monthly for one year to ensure the Committee is embracing the QAPI Process and utilizing it to the fullest extent possible to improve services provided. Results of these audits will be brought to QAPI for three months for further review and recommendations. 5. Date of completion: 11.11.2024	

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F 867	Continued From page 121 facility's incident report documented that R322 was administered another resident's medications by E43 (RN) which resulted in R322 being emergently transferred to the hospital and admission to the Intensive Care Unit for treatment and monitoring. The facility lacked evidence that a quality assurance and performance improvement process was implemented immediately and followed-through with respect to R322's significant medication error and the failure to ensure E43 had a medication adminstration competency and skill set upon orientation. 8/26/24 at 12:50 PM - During an interview, E48 (Staff Educator) confirmed that she had no evidence of E43's medication administration competency and skill set. 9/10/24 at 2:10 PM - Finding was reviewed during exit conference with E1 (NHA).	F 867		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;	F 883		11/11/24

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F 883	Continued From page 122 (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical	F 883		

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F 883	Continued From page 123 contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R21) out of five residents reviewed for immunizations, the facility failed to provide evidence that the Pneumococcal vaccine was offered or declined. Additionally, for one (R26) out of the same five residents reviewed for immunizations, the facility failed to provide evidence that the influenza vaccine was offered or declined. Findings include: 1. The facility policy on pneumococcal vaccination last updated, 8/4/23 indicated, "Vaccination against pneumonia will be offered to center patients as indicated. If vaccine is not provided document reasoning in the medical record." Review of R21's clinical record revealed: 2/11/23 - R21 was admitted to the facility. 8/5/24 11:44 AM - Review of resident immunization lacked evidence of administration or declination of the pneumococcal vaccine to R21. An email request was sent to E3 (ADON) for evidence of administration or declination of the Pneumococcal vaccine. 2. The facility policy on influenza immunization last updated, 5/1/23 indicated, "Influenza should be offered annually. If vaccine is not provided, document reasoning in the medical record." Review of R26's clinical record revealed: 6/29/23 - R26 was admitted to the facility.	F 883	F-883 1. Upon discovery, R21 and R26 were assessed with no adverse affects to this deficient practice noted. Both residents □ along with all current residents □ will be offered the pneumococcal and influenza vaccines as part of the facility□s vaccination program in Autumn of 2024. 2. All residents have the potential to be affected. 3. Unit Managers will be educated on the policy and procedure for offering and documenting immunizations by DON or designee. All residents will be offered the pneumococcal and influenza vaccines as part of the facility□s vaccination program. 4. Once the vaccination program has started, an audit of resident□s immunization documentation will be conducted weekly to ensure residents have been offered the appropriate vaccines and documentation is completed by the DON or ADON. Throughout flu season, new resident files will be audited to ensure vaccination documentation is completed. Results of these audits will be brought to QAPI Committee monthly for three months for further review and recommendations. 5. Date of completion: 11.11.2024	

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F 883	Continued From page 124 11/28/23 - R26 received education on the influenza vaccine. 8/5/24 11:44 AM - Review of resident immunization lacked evidence of administration or declination of the influenza vaccine to R26. An email request was sent to E3 (ADON) for evidence of administration or declination for both residents missed immunizations. During an interview on 8/6/24 at 12:46 PM, E3 (ADON) and (ICP) confirmed the findings and that the declination's or administrations for both R21 and R26 related to the aforementioned vaccinations could not be located. 8/12/24 2:15 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON), E10 (VPO) and a State of DE Ombudsman (via telephone).	F 883		
F 887 SS=D	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and	F 887		11/11/24

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F 887	Continued From page 125 risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses; (v) The resident, resident representative, or staff member has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident; or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN).	F 887		

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F 887	Continued From page 126 This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined that one (R26) out of five residents sampled for COVID-19 Immunization the facility failed to provide evidence that R26 had consented or declined to be given the COVID-19 vaccine. Findings include: The facility's policy on COVID-19 vaccines last updated 3/11/24 indicated, "The CDC recommends that everyone stay up to date with the use of COVID-19 vaccines to prevent the spread of COVID-19...Provide education using vaccine information statement. Document attempts and refusals." Review of R26's clinical record revealed: 6/29/23 - R26 was admitted to the facility. 11/28/23 - R26 received education on the COVID-19 vaccine. 8/5/24 11:44 AM - Review of R26's immunization record lacked evidence of any COVID-19 vaccination. An email request for evidence of administration or declination of the COVID-19 vaccine was requested from E3 (ADON) (ICP). During an interveiw on 8/6/24 at 12:45 PM, E3 (ADON) and (ICP) confirmed the facility lacked evidence that R26 received or declined the COVID-19 vaccine. 8/12/24 2:15 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON), E10 (VPO) and a State of DE Ombudsman (via telephone).	F 887	F-887 1. R26 continues to reside at the facility and has been presented the education for the COVID-19 vaccination. He wishes to get the COVID-19 vaccination. Will administer upon delivery from the pharmacy. 2. All residents that have not received the COVID-19 vaccination have the potential to be affected by this practice. The Infection Control Practitioner will audit of all residents who have not received the COVID-19 vaccination to provide education on vaccination to identified resident, administer and document if the resident consents or document declination if resident refuses. 3. Root cause analysis completed results identified that the facility failed to follow the COVID-19 Vaccination policy. Upon admission (the admission nurse) and per administration frequency guidelines, the resident will be offered applicable immunizations if they have not yet received them or are due for the immunization. The resident will be provided education on the immunization via the Vaccine Immunization Statement by Licensed Nurse. If the resident consents to the immunization, it will be administered per order and documented in the medication record. If they decline the immunization, the declination will be recorded in the record. New admission chart checks will also review for documentation of accepting/declining applicable vaccinations. RDSC will	

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F 887	Continued From page 127	F 887	educate all licensed nurses on the policy regarding COVID-19 Vaccination and record keeping. Declinations will be documented in the immunization tab. 4. IP/designee will audit 5 residents for COVID-19 education and consent/declination of vaccine weekly X 4 weeks until 100%, then every 2 weeks X 1 month until 100%, then monthly X 4 months until 100%. All audits will be submitted to the QAA committee monthly. The results of the audits will be reported X 4 months. The QAA committee will determine what, if any, additional intervention is needed at the end of the 4 months. 5. Date of completion: 11.11.2024	
F 941 SS=E	Communication Training CFR(s): 483.95(a) §483.95(a) Communication. A facility must include effective communications as mandatory training for direct care staff. This REQUIREMENT is not met as evidenced by: Based on interview and review of the facility's policy and procedure, it was determined that the facility failed to ensure mandatory effective communication training was completed for all direct care staff. Findings include: 3/8/21 - The facility's policy and procedure entitled "LEP/Auxiliary Aid Services" documented, "In order to ensure effective communication with patients and their companions, the Center will provide appropriate auxilliary aids and services, where necessary, including, but not limited to,	F 941	F-941 1. No residents were affected by the deficient practice. 2. All residents have the potential to be affected by the deficient practice. 3. A root cause analysis identified the facility did not have a process in place to track and monitor adherence to required staff training for staff providing direct and indirect care and services for the residents. In addition to E48, all facility staff will be educated on regulation F941.	11/11/24

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F 941	Continued From page 128 qualified sign language interpreters for patients and their companions who are deaf or have hearing loss, as well as aids and services to those who are vision impaired or have limited English proficiencies... 11. The Center will provide mandatory ADA (Americans with Disabilities Act) training for all employees and contract employees who are affiliated with the Center who might interact with patients and/or companions who have communication impairments. Training will also be included in new hire orientation and will be incorporated in the training library for all employees annually." 8/8/24 at 11:15 AM - During an interview, E48 (Staff Development) stated that she started working with the facility in April 2024. When the Surveyor asked for evidence of communication training for all direct care staff, E48 stated that was not part of the current facility orientation and mandatory annual training. E48 stated that she does not have any evidence that it was being done by the previous staff educator. The Surveyor and E48 reviewed that this includes staff education on alternative means of communication for residents that do not use the English language, for example using a qualified translation service, communication boards, etc. 8/12/24 at 2:15 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON), E10 (VPO) and a State of DE Ombudsman (via telephone).	F 941	A 100% audit of employee files will be conducted by the Human Resources Director/Designee. The Administrator will educate the Human Resources Director and Staff Development Coordinator on ensuring that all new and existing staff meet the trainings requirements as set forth by CMS. The Director of HR will generate a monthly report to validate adherence to the training requirements for F941. SDC will ensure the identified staff are notified of missed education. If any active employee is found not in compliance, the employee, the DON and the Administrator will be notified. Failure of staff to adhere to the expected requirements will be subjected to progressive discipline. 4. The Human Resources Director/Designee will audit 10 existing and 3 newly hired employee files to ensure compliance with the required training weekly x 4 weeks until 100%, then every 2 weeks x 1 month until 100%, then monthly x 4 months until 100%. All audits will be submitted to the QAA committee monthly. The results of the audits will be reported X 4 months. The QAA committee will determine what, if any, additional intervention is needed at the end of the 4 months. 5. Date of completion: 11.11.2024	
F 943 SS=D	Abuse, Neglect, and Exploitation Training CFR(s): 483.95(c)(1)-(3) §483.95(c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12,	F 943		11/11/24

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F 943	Continued From page 129 facilities must also provide training to their staff that at a minimum educates staff on- §483.95(c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. §483.95(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property §483.95(c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on interview and review of facility documentation it was determined that for three (E14, E27 and E28) out of nine employees sampled the facility failed to provide abuse, neglect, exploitation, and dementia training at least annually. In addition, E21 did not have dementia training. Findings include: The facility was provided a list of nine names selected randomly and instructed to provide documentation of in-service training for abuse, neglect, exploitation, and dementia training for new and existing staff. 8/7/24 11:00 AM - During an interview and record review with E34 (HR) it was confirmed: 1. E14 had a hire date of 9/1/22. E14's record review lacked evidence of abuse and dementia training. 2. E27 had a hire date of 7/22/08. E27's record review lacked evidence of abuse and dementia training.	F 943	F-943 1. No residents were affected by the deficient practice. 2. All residents have the potential to be affected by the deficient practice. 3. A root cause analysis identified the facility did not have a process in place to track and monitor adherence to required staff training for staff providing direct and indirect care and services for the residents. In addition to E14, E27, E28, E21, all facility staff will be educated on regulation F943. A 100% audit of employee files will be conducted by the Human Resources Director/Designee. The Administrator will educate the Human Resources Director and Staff Development Coordinator on ensuring that all new and existing staff meet the trainings requirements as set forth by CMS. The Director of HR will generate a monthly report to validate adherence to the training requirements for F943. SDC will ensure	

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F 943	Continued From page 130 3. E28 had a hire date of 10/3/23. E28's record review lacked evidence of abuse and dementia training. 4. E21 had a hire date 3/5/24. E21's record review lacked evidence of dementia training. 8/12/24 1:34 PM - Findings were confirmed with E2 (DON) and E3 (ADON). 8/12/24 2:15 PM - Findings were reviewed with E1 (NHA), E2, (DON), E3, (ADON), E10 (VPO) and a State of DE Ombudsman (via telephone).	F 943	the identified staff are notified of missed education. If any active employee is found not in compliance, the employee, the DON and the Administrator will be notified. Failure of staff to adhere to the expected requirements will be subjected to progressive discipline. 4. The Human Resources Director/Designee will audit 10 existing and 3 newly hired employee files to ensure compliance with the required training weekly x 4 weeks until 100%, then every 2 weeks x 1 month until 100%, then monthly x 4 months until 100%. All audits will be submitted to the QAA committee monthly. The results of the audits will be reported X 4 months. The QAA committee will determine what, if any, additional intervention is needed at the end of the 4 months. 5. Date of completion: 11.11.2024	
F 944 SS=E	QAPI Training CFR(s): 483.95(d) §483.95(d) Quality assurance and performance improvement. A facility must include as part of its QAPI program mandatory training that outlines and informs staff of the elements and goals of the facility's QAPI program as set forth at § 483.75. This REQUIREMENT is not met as evidenced by: Based on interview and review of facility documentation, it was determined that for two (E57 and E58) out of five nursing staff reviewed, the facility failed to ensure that the required QAPI (Qualify Assurance And Performance Improvement) training was completed. Findings	F 944	F-944 1. No residents were affected by the deficient practice. 2. All residents have the potential to be affected by the deficient practice. 3. A root cause analysis identified the	11/11/24

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F 944	Continued From page 131 include: 8/26/24 1:00 PM - Review of the agency staff training records revealed a lack of evidence of QAPI training of the following agency staff: 3/25/24 - E57's first day in the facility assigned as Agency RN. 7/16/24 - E58' s first day in the facility assigned as Agency LPN. 8/26/24 1:30 PM - During an interview, E48 (Staff Educator) confirmed that E57 and E58 did not have records of the QAPI trainings on their files. 8/26/24 2:33 PM - Findings were discussed with E1 (NHA). 8/27/24 2:52 PM - Findings were reviewed with E1 (NHA), E2 (DON) and E10 (VPO).	F 944	facility did not have a process in place to track and monitor adherence to required staff training for staff providing direct and indirect care and services for the residents. In addition to E14, E27, E28, and E21, all facility staff will be educated on regulation F944. A 100% audit of employee files will be conducted by the Human Resources Director/Designee. The Administrator will educate the Human Resources Director and Staff Development Coordinator on ensuring that all new and existing staff meet the trainings requirements as set forth by CMS. The Director of HR will generate a monthly report to validate adherence to the training requirements for F944. SDC will ensure the identified staff are notified of missed education. If any active employee is found not in compliance, the employee, the DON and the Administrator will be notified. Failure of staff to adhere to the expected requirements will be subjected to progressive discipline. 4. The Human Resources Director/Designee will audit 10 existing and 3 newly hired employee files to ensure compliance with the required training weekly x 4 weeks until 100%, then every 2 weeks x 1 month until 100%, then monthly x 4 months until 100%. All audits will be submitted to the QAA committee monthly. The results of the audits will be reported X 4 months. The QAA committee will determine what, if any, additional intervention is needed at the end of the 4 months. 5. Date of completion: 11.11.2024	

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 _____	C 09/10/2024

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F 946 SS=E	Compliance and Ethics Training CFR(s): 483.95(f)(1)(2) §483.95(f) Compliance and ethics. The operating organization for each facility must include as part of its compliance and ethics program, as set forth at §483.85- §483.95(f)(1) An effective way to communicate the program's standards, policies, and procedures through a training program or in another practical manner which explains the requirements under the program. §483.95(f)(2) Annual training if the operating organization operates five or more facilities. This REQUIREMENT is not met as evidenced by: Based on interview and review of facility documentation, it was determined that for two (E57 and E58) out of five nursing staff reviewed, the facility failed to ensure that the required training on Compliance and Ethics Program was completed. Findings include: 8/26/24 1:00 PM - Review of the employee training records revealed a lack of evidence of Compliance and Ethics Program training of the following staff: 3/25/24 - E57's first day in the facility assigned as Agency RN. 7/16/24 - E58' s first day in the facility assigned as Agency LPN. 8/26/24 1:31 PM - During an interview, E48 (Staff Educator) confirmed that E57 and E58 did not have records of the Compliance and Ethics Program trainings on their files.	F 946	F-946 1. No residents were affected by the deficient practice. 2. All residents have the potential to be affected by the deficient practice. 3. A root cause analysis identified the facility did not have a process in place to track and monitor adherence to required staff training for staff providing direct and indirect care and services for the residents. In addition to E57, and E58, all facility staff will be educated on regulation F946. A 100% audit of employee files will be conducted by the Human Resources Director/Designee. The Administrator will educate the Human Resources Director and Staff Development Coordinator on ensuring that all new and existing staff meet the trainings requirements as set forth by CMS. The Director of HR will generate a monthly report to validate adherence to the training	11/11/24

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F 946	Continued From page 133 8/26/24 2:33 PM - Findings were discussed with E1 (NHA). 8/27/24 2:52 PM - Findings were reviewed with E1 (NHA), E2 (DON) and E10 (VPO).	F 946	requirements for F946. SDC will ensure the identified staff are notified of missed education. If any active employee is found not in compliance, the employee, the DON and the Administrator will be notified. Failure of staff to adhere to the expected requirements will be subjected to progressive discipline. 4. The Human Resources Director/Designee will audit 10 existing and 3 newly hired employee files to ensure compliance with the required training weekly x 4 weeks until 100%, then every 2 weeks x 1 month until 100%, then monthly x 4 months until 100%. All audits will be submitted to the QAA committee monthly. The results of the audits will be reported X 4 months. The QAA committee will determine what, if any, additional intervention is needed at the end of the 4 months. 5. Date of completion: 11.11.2024	
F 947 SS=D	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews	F 947		11/11/24

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F 947	Continued From page 134 and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on interview and review of facility documentation, it was determined that for three (E14, E26 and E27) out of five sampled CNA's (Certified Nursing Assistants) reviewed the facility failed to ensure that these employees had the mandatory twelve hours of annual in-service training. Findings include: 8/7/24 11:00 AM - Review of the staff training hours documentation revealed the following: 1. E14 (CNA) with a hire date of 9/1/22 had zero hours of annual in-service training and was confirmed by E34 (HR). 2. E26 (CNA) with a hire date of 3/4/08 had 11.25 hours of training and was confirmed by E34. 3. E27 (CNA) with a hire date of 7/22/08 had zero hours of annual in-service training and was confirmed by E34. 8/12/24 1:34 PM - Findings were confirmed with E2 (DON), E3 (ADON). The facility lacked evidence that these employees completed the mandatory twelve hours of annual in-service training. 8/12/24 2:15 PM - Findings were reviewed with	F 947	F-947 1. No residents were affected by the deficient practice. 2. All residents have the potential to be affected by the deficient practice. 3. A root cause analysis identified the facility did not have a process in place to track and monitor adherence to required staff training for staff providing direct and indirect care and services for the residents. In addition to E14, E26, E27 all facility staff will be educated on regulation F947. A 100% audit of employee files will be conducted by the Human Resources Director/Designee. The Administrator will educate the Human Resources Director and Staff Development Coordinator on ensuring that all new and existing staff meet the trainings requirements as set forth by CMS. The Director of HR will generate a monthly report to validate adherence to the training requirements for F943. SDC will ensure the identified staff are notified of missed education. If any active employee is found not in compliance, the employee, the DON and the Administrator will be notified. Failure of staff to adhere to the expected requirements will be subjected to progressive discipline.	

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F 947	Continued From page 135 E1 (NHA), E2 (DON), E3 (ADON), E10 (VPO) and a State of DE Ombudsman (via telephone).	F 947	4. The Human Resources Director/Designee will audit 10 existing and 3 newly hired employee files to ensure compliance with the required training weekly x 4 weeks until 100%, then every 2 weeks x 1 month until 100%, then monthly x 4 months until 100%. All audits will be submitted to the QAA committee monthly. The results of the audits will be reported X 4 months. The QAA committee will determine what, if any, additional intervention is needed at the end of the 4 months. 5. Date of completion: 11.11.2024	
F 949 SS=E	Behavioral Health Training CFR(s): 483.95(i) §483.95(i) Behavioral health. A facility must provide behavioral health training consistent with the requirements at §483.40 and as determined by the facility assessment at §483.70(e). This REQUIREMENT is not met as evidenced by: Based on interview and review of facility documentation, it was determined that for five (E43, E55, E56, E57 and E58) out of five nursing staff reviewed, the facility failed to ensure that the required Behavioral Health training was completed. Findings include: 8/26/24 1:00 PM - Review of the employee training records revealed a lack of evidence of Behavioral Health training of the following staff: 6/4/24 - E43's first day in the facility hired for the Registered Nurse (RN) position.	F 949	F-949 1. No residents were affected by the deficient practice. 2. All residents have the potential to be affected by the deficient practice. 3. A root cause analysis identified the facility did not have a process in place to track and monitor adherence to required staff training for staff providing direct and indirect care and services for the residents. In addition to E43, E55, E56, E57 and E58, all facility staff will be educated on regulation F949. A 100% audit of employee files will be conducted	11/11/24

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F 949	Continued From page 136 6/24/24 - E55's first day in the facility hired for the Licensed Practical Nurse (LPN) position. 7/8/24 - E56's first day in the facility hired for the LPN position. 3/25/24 - E57's first day in the facility assigned as Agency RN. 7/16/24 - E58' s first day in the facility assigned as Agency LPN. 8/26/24 1:30 PM - During an interview, E48 (Staff Educator) confirmed that E43, E55, E56, E57 and E58 did not have records of the Behavioral Health trainings on their files. 8/26/24 2:33 PM - Findings were discussed with E1 (NHA). 8/27/24 2:52 AM - Findings were reviewed with E1 (NHA), E2 (DON) and E10 (VPO).	F 949	by the Human Resources Director/Designee. The Administrator will educate the Human Resources Director and Staff Development Coordinator on ensuring that all new and existing staff meet the trainings requirements as set forth by CMS. The Director of HR will generate a monthly report to validate adherence to the training requirements for F949. SDC will ensure the identified staff are notified of missed education. If any active employee is found not in compliance, the employee, the DON and the Administrator will be notified. Failure of staff to adhere to the expected requirements will be subjected to progressive discipline. 4. The Human Resources Director/Designee will audit 10 existing and 3 newly hired employee files to ensure compliance with the required training weekly x 4 weeks until 100%, then every 2 weeks x 1 month until 100%, then monthly x 4 months until 100%. All audits will be submitted to the QAA committee monthly. The results of the audits will be reported X 4 months. The QAA committee will determine what, if any, additional intervention is needed at the end of the 4 months. 5. Date of completion: 11.11.2024	