STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085003	A. BUILDING _____ B. WING _____	C 07/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOKE COURT AT COUNTRY HOUSE	4830 KENNETT PIKE WILMINGTON, DE 19807

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F 881	Continued From page 63 6/10/19, however, there were no additional orders written and no progress note written justifying continued use of the antibiotic in the presence of a negative culture. 6/27/19 8:35 AM - A progress note stated, "...14 day MDS completed:..resident was being treated for suspected UTI although McGreer's criteria not met...". The facility failed to discontinue R44's Macrobid when the negative culture was reported on 6/8/19. R44 received Macrobid 100 mg twice daily from 6/7/19 through 6/17/19 without an indication for use and in the presence of a negative culture report. The facility failed to implement their antibiotic stewardship program. 7/8/19 approximately 5:00 PM - Findings were reviewed with E2 (former DON). 7/15/19 approximately 12:30 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (former DON), E3 (acting DON), E6 (NP), and E16 (ED).	F 881		

ASPEN

SEVERITY/SCOPE GRID

Name: WILLOWBROOKE COURT AT COUNTRY HOUSE
4830 KENNETT PIKE
WILMINGTON, DE 19807

Provider 085003

Survey Date 07/15/2019

Survey Event ID: N66611

Survey Types Recertification, Complaint Investig.

SUMMARY OF DEFICIENCIES

Level 4	**J** F0678	**K**	**L**
Level 3	**G**	**H**	**I**
Level 2	**D** F0550 F0580 F0622 F0661 F0684 F0689 F0730 F0755 F0758 F0760 F0881	**E** F0725 F0867	**F** F0812
Level 1	**A**	**B**	**C**

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E 000	Initial Comments An unannounced annual, complaint and emergency preparedness surveys were conducted at this facility from 7/1/19 to 7/15/19 by the State of Delaware Division of Health Care Quality, Office of Long Term Care Residents Protection in accordance with 42 CFR 483.73. The facility census the first day of the survey was 43. For the Emergency Preparedness survey, all contracts, operations plan, contact information, and annual emergency drills were up to date. No deficiencies were identified.	E 000		
F 000	INITIAL COMMENTS An unannounced annual, complaint and emergency preparedness surveys were conducted at this facility from 7/1/19 to 7/15/19. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census the first day of the survey was 43. The survey sample size was 34. Abbreviations/word definitions used in this report are as follows: & - and; Abated - remove; ADLs - Activities of daily living - tasks needed for daily living, e.g. dressing, hygiene, eating, toileting, bathing; ADON - Assistant Director of Nursing; ALS - Advanced Life Support/resuscitation maneuvers that extend beyond basic cardiopulmonary resuscitation (CPR); antipsychotic - drugs that are used to treat	F 000		

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

Electronically Signed | 08/12/2019

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1	F 000		

symptoms of psychosis such as delusions (for example, hearing voices), hallucinations, paranoia, or confused thoughts;
Apneic - not breathing;
Articulate - having or showing the ability to speak fluently and coherently;
BLS - Basic Life Support/resuscitation using CPR;
cm - centimeter;
C&S - Culture and Sensitivity/a culture is a test to find germs (such as bacteria or a fungus) that can cause an infection. A sensitivity test checks to see what kind of medicine, such as an antibiotic, will work best to treat the illness or infection;
CNA - Certified Nurse's Aide;
Coherent - logical and consistent;
CPAP - machine for breathing assistance during sleep;
CPR - Cardiopulmonary Resuscitation/an emergency procedure that is done when someone's breathing or heartbeat has stopped in hopes of providing time for first responders to arrive;
DON - Director of Nursing;
DMOST - Delaware Medical Orders for Scope of Treatment/a doctor 's order that helps you keep control over medical care at the end of life. The form tells emergency medical personnel and other health care providers whether or not to administer cardiopulmonary resuscitation (CPR) in the event of a medical emergency;
DNH - Do not hospitalize;
DNI - Do not intubate;
DNR - Do not resuscitate/a medical order written by a doctor. It instructs health care providers not to do cardiopulmonary resuscitation (CPR) if a patient's breathing stops or if the patient's heart stops beating;
ED - Executive Director;

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F 000	Continued From page 2 eMAR - electronic Medication Administration Record; EMS - Emergency Medical Services; eTAR - electronic Treatment Administration Record; Faint - weak; Foley catheter - a hollow, flexible tube that is inserted into the bladder through the urethra to drain urine; Frontal Sinusitis - acute bacterial infection of the frontal sinus cavity; H&P - History and Physical; Hospice - service that provides care to residents that are terminally ill; Hoyer - mechanical lift that utilizes a sling used to transfer people who are unable to stand or bear their full weight between a bed and a chair or other places; Immediate Jeopardy - a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident; Incapacitated - unable to act or respond; Intravenous (IV) - administration of medications/fluids through a tube directly into a vein; Kardex - CNA plan of care for individual residents; Lacosamide - medication used to treat seizure disorder; Lethargic/lethargically - abnormal drowsiness; LPN - Licensed Practical Nurse; LTC - Long Term Care; McGreer criteria - guidelines for treatment of infections; MD/md - medical doctor; mg - milligram; NHA - Nursing Home Administrator;	F 000		

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F 000	Continued From page 3 NP - Nurse Practitioner; Osteomyelitis - infection and inflammation of the bone; OT - Occupational Therapy; POA - Power of Attorney; PRN/prn - as needed; pt - patient; PT - Physical Therapy; Quality Assurance - the specification of standards for quality of care, service and outcomes, and systems throughout the facility for assuring that care is maintained at acceptable levels in relation to those standards; Recap - monthly facility review of physician's orders to ensure completeness and accuracy before the orders are signed by the resident's physician; Recapitulation - a concise summary of a resident's stay and course of treatment in the facility; Resp. - respiration/breathing; Resuscitation - revive (someone) from unconsciousness or apparent death; RN - Registered Nurse; RNAC - Registered Nurse Assessment Coordinator; Rollator - a mobility aide; Seizure Disorder - abnormal electrical activity in the brain causing repetitive muscle jerking; Sternal Rub - application of painful stimulus with the knuckles of closed fist to the center chest of a patient who is not alert and does not respond to verbal stimuli; Subdural Empyema - acute bacterial infection that collects in the space between the middle and outer layer of tissues covering the brain; SW - Social Worker; UA - urinalysis/analysis of urine by physical, chemical, and microscopic means to test for the	F 000		

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F 000	Continued From page 4 presence of disease, drugs, etc.; WC - wheelchair.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.	F 550		8/30/19

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F 550	Continued From page 5 §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record review and interview, it was determined that the facility failed to ensure that one (R44) out of two residents reviewed for the care area of urinary catheter/urinary tract infection was treated with respect and dignity. Findings include: Review of R44's clinical record revealed the following: 6/5/19 - A care plan was developed for indwelling Foley catheter use. Interventions included, "...position catheter bag and tubing below the level of the bladder and away from entrance room door for my dignity...". The following observations were made of R44: 7/2/19 8:58 AM - R44 was observed seated in a recliner in his/her room watching TV. The Foley catheter drainage bag was hanging on the wheel of a wheelchair next to R44 and was visible from the doorway of R44's room. The drainage bag was not covered and the urine was very bloody. 7/2/19 10:16 AM - R44 remained seated in a recliner in his/her room with the urinary drainage bag still hanging on the wheelchair containing bloody urine visible from the doorway. 7/3/19 9:39 AM - R44 was seated in a recliner in	F 550	Preparations and/or execution of this plan of correction does not constitute admission or agreement by the providers of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared solely as a matter of compliance with federal and state law. F550 A. A foley catheter privacy bag was provided to R44 for use in his private room when sitting in his recliner. B. The DON/Designee will audit current resident for use of foley catheter and ensure privacy bags are provided for use inside of resident's room. C. A Root Cause analysis was completed and it was determined that applicable policies would be reviewed with staff to ensure that staff are aware that when resident is in private room, the catheter drainage bag will also be in a privacy bag when resident is visible to others from outside of the room or to those entering the room.	

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F 550	Continued From page 6 his/her room asleep. The urinary drainage bag was hanging on a rollator next to the resident. The drainage bag was currently empty, but not covered and visible from the doorway. 7/8/19 10:40 AM - R44 was seated in a recliner in his/her room with eyes closed. The urinary drainage bag was hanging on a rollator next to him/her, not covered and visible from hallway. The facility failed to ensure that R44 was treated with respect and dignity when his/her catheter drainage bag was left uncovered and visible to anyone in the hallway and/or entering the room. 7/8/19 approximately 5:00 PM - Findings were reviewed with E2 (former DON). 7/15/19 approximately 12:30 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (former DON), E3 (acting DON), E6 (NP), and E16 (ED).	F 550	The DON/Designee will in-service licensed nurses and C.N.A.s that catheter bags will be placed in privacy bags when resident is outside of resident room and inside of their bedrooms. D. The DON/Designee will conduct of audits of residents with foley catheters to ensure that privacy bags are in use when the resident is inside their room and visible from outside of the room. These audits will be conducted daily until we reach success for 3 consecutive days, then three times a week until we reach success for three consecutive weeks, then once weekly until we reach success for three consecutive weeks, then once a month until we determine 100% compliance has been achieved. Outcomes of the audits will be reported at the Quarterly QAPI meeting for review and recommendation as indicated.	
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or	F 580		8/30/19

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F 580	Continued From page 7 clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on clinical record review, interview and review of facility documentation as indicated, it	F 580	F580	

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F 580	Continued From page 8 was determined that for 1 out of 1 death record sampled, the facility failed to notify the resident's physician when R48 did not receive 2 doses of Lacosamide medication and R48 had a new diagnosis of seizure disorder. Findings include: The facility's policy entitled Physician Notification, last revised in 6/2014, stated, "... Procedure: 1. The licensed nurse is responsible for notifying the resident's physician at a minimum when there is:... j. The inability to obtain or administer on a prompt and timely basis prescribed medications... 5. Record the following in the resident's health record: a. All attempts to notify the physician or on-call physician, method of attempted contact, time and individuals contacted... b. Reported assessment findings. c. Additional information provided. d. Physician's response. e. Physician's orders. f. Resident's status and response to the treatment ordered. g. Notification of family or legal representative provided and the family or legal representative response." Review of R48's clinical record revealed: 5/28/19 - The hospital's Medication Orders Upon Discharge stated to administer the next dose of Lacosamide to R48 at 10 PM tonight (5/28/19). 5/28/19 at approximately 12 Noon - R48 was admitted to the facility with a diagnosis of new onset of seizure disorder. 5/28/19 - A physician's order stated to administer Lacosamide two times a day for R48's seizure disorder. 5/28/19 - Review of R48's May 2019 eMAR and corresponding Order-Administration Note at	F 580	A. R48 no longer resides in facility. B. Current residents residing at Willowbrooke Court at Country House have the potential to be impacted by the identified area of concern and facility will ensure that physician notification for missed medications due to not arriving from pharmacy is completed. C. A Root Cause analysis was completed on the identified area of concern and it was determined that licensed nursing staff required education on the policy for Physician Notification as it relates to missed medications due to medications not arriving from the pharmacy. The DON/Designee will in-service licensed nurses on the Physician Notification policy as it relates to notifying physician in instances of missed medications when medication have not arrived timely from pharmacy. D. The DON/Designee will audit resident medical records to ensure residents who have missed medications due to not arriving from pharmacy, that physician is notified. These audits will be conducted daily until we reach success for 3 consecutive days, then three times a week until we reach success for three consecutive weeks, then once weekly until we reach success for three consecutive weeks, then once a month until we determine 100% compliance has been achieved.	

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F 580	Continued From page 9 10:33 PM revealed that R48 did not receive Lacosamide at 8 PM because they were waiting for the pharmacy to deliver the medication. Review of R48's clinical record lacked evidence that the physician was notified of the inability to obtain and administer the above medication to R48 on 5/28/19 at 8 PM. 5/29/19 at 1:27 AM - The pharmacy's Proof of Delivery report for R48 revealed that Lacosamide was delivered to the facility at this time. 5/29/19 at 8 AM - Review of R48's eMAR revealed that he/she received the 8 AM dose of Lacosamide. 5/29/19 at 8:45 PM - An Order-Administration Note, written by E24 (RN), for R48's Lacosamide stated, "...Not delivered yet from (name) pharmacy." Despite having received the Lacosamide medication from pharmacy on 5/29/19 at 1:27 AM and R48 receiving the 8 AM dose, R48 was not administered the medication at 8 PM. Review of R48's clinical record lacked evidence that R48's physician was notified that R48's anti-seizure medication was not administered. 7/10/19 at 2:36 PM - During a combined interview with E2 (former DON) and E4 (ADON), E2 stated that when a physician was contacted, nurses should be documenting this information in the progress notes. 7/11/19 at 12:30 PM - Findings were reviewed during the Exit Conference with E1 (NHA), E2 (former DON), E3 (acting DON), E6 (NP) and E16 (ED). The facility failed to notify the physician when R48's Lacosamide medication was not	F 580	Outcomes of these audits will be reported to the Quarterly QAPI Committee meeting for review and recommendation as indicated.	

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F 580	Continued From page 10 available and/or administered.	F 580		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or	F 622		8/30/19

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F 622	Continued From page 11 discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including	F 622		

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F 622	Continued From page 12 contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on clinical record review and interview, it was determined that for one (R47) out of one Admission, Transfer, Discharge sampled resident, the facility failed to ensure that appropriate information was communicated to the receiving health care provider to ensure a safe and effective transition of care for R47. Findings include: Review of R47's clinical record revealed: 3/13/19 - R47 was admitted to the facility for skilled nursing and rehabilitation. 4/16/19 - A physician's order stated that R47 was discharged to an assisted living facility. Review of R47's clinical record lacked evidence that the facility provided the following information to the receiving health care provider: - lab results dated 4/16/19; - an accurate ADL status of R47 and current vital signs on the interagency nursing communication record; - updated comprehensive care plan; - special instructions/precautions for ongoing care, including adaptive equipment needs; and	F 622	F622 A. The Discharge Assessment & Summary and the Discharge Plan of Care/Instructions-DE have been forwarded to R47's receiving facility. B. The DON/Designee will audit current residents to identify residents who have the potential to be discharged (residents who are not currently permanent residents of Willowbrooke Court at Country House) and as discharge dates are determined, will ensure that Discharge Summary policy is followed. C. A Root Cause analysis was completed on the identified area of concern and it was determined that the facility did not have a system in place to ensure that the minimum required documents were sent to the receiving facility. System change will include a Discharge Checklist to ensure that these documents are sent with residents to the receiving provider. The DON/Designee will in-service on the	

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F 622	Continued From page 13 - a copy of the resident's discharge summary. 7/9/19 at 11:38 AM - During an interview, E17 (SW) stated that he/she did not send R47's care plan to the receiving provider. 7/15/19 at 12:30 PM - Findings were reviewed during the Exit Conference with E1 (NHA), E2 (former DON), E3 (acting DON), E6 (NP) and E16 (ED). The facility failed to ensure that appropriate information was communicated to the receiving health care provider to ensure a safe and effective transition of care for R47.	F 622	Assistant Director of Nursing, the Nurse Manager, and the Social Services Coordinator on the requirement that appropriate documents are sent with resident to the receiving provider and that the checklist will be utilized as a tool to ensure documents are sent. D. The DON/Designee will audit the records of residents set for discharge to ensure that minimum required documents are being sent to the receiving facility. These audits will be conducted once weekly until we reach success for 3 consecutive weeks, then twice monthly until we reach success for two consecutive months, then once a month until we determine 100% compliance has been achieved. Outcomes of these audits will be reported at the Quarterly QAPI Committee meeting for review and recommendation as indicated.	
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for	F 661		8/30/19

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F 661	Continued From page 14 release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on clinical record review and interview, it was determined that for one (R47) out of one Admission, Transfer, Discharge sampled resident, the facility failed to develop R47's discharge summary that included a recapitulation of R47's stay, a final summary of the resident's status and post-discharge plan of care, including discharge instructions. Findings include: Review of R47's clinical record revealed: 3/13/19 - R47 was admitted to the facility for skilled nursing and rehabilitation. 4/16/19 - A physician's order stated that R47 was discharged to an assisted living facility. Review of R47's clinical record lacked evidence of a complete discharge summary that included: - a recapitulation of R47's stay at the facility that	F 661	F661 A. The Discharge Assessment & Summary and the Discharge Plan of Care/Instructions-DE have been forwarded to R47's receiving facility. B. The DON/Designee will audit current residents to identify residents who have the potential to be discharged (residents who are not currently permanent residents of Willowbrooke Court at Country House). C. A Root Cause analysis was completed on the identified area of concern and it was determined that the facility did not have a system in place to ensure that the Discharge Assessment & Summary and the Discharge Plan of Care/Instructions were sent with the resident to the	

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F 661	Continued From page 15 included, but was not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology and consultation results; and - a post-discharge plan of care that was developed with the participation of the resident, including any arrangements that have been made for the resident's follow-up care and any post-discharge medical and non-medical services. 7/9/19 at 11:27 AM - During a combined interview, findings were reviewed with E1 (NHA), E2 (former DON), E3 (acting DON), E17 (SW) and E4 (ADON). The facility failed to develop a discharge summary that included a recapitulation of R47's stay, a final summary of the resident's status and post-discharge plan of care, including discharge instructions.	F 661	receiving provider and copied maintained in the resident's closed record. To ensure these documents are sent, they will be included on the Discharge Checklist. The DON/Designee will in-service the Assistant Director of Nursing, the Nurse Manager, and the Social Services Coordinator on the Discharge Summary policy. D. The DON/Designee will audit the records of residents set for discharge to ensure that the Discharge Assessment & Summary and the Discharge Plan of Care/Instructions are being sent to the receiving facility. These audits will be conducted once weekly until we reach success for 3 consecutive weeks, then twice monthly until we reach success for two consecutive months, then once a month until we determine 100% compliance has been achieved. Outcomes of these audits will be reported at the Quarterly QAPI Committee meeting for review and recommendation as indicated.	
F 678 SS=J	Cardio-Pulmonary Resuscitation (CPR) CFR(s): 483.24(a)(3) §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced	F 678		8/30/19

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F 678	Continued From page 16 by: Based on review of clinical records, interviews and review of facility and other documentation as indicated, it was determined that for 1 (R48) out of 1 death record the facility failed to have an effective system to coordinate, document and implement DNR code status. The facility failed to have a process in place that guaranteed a discussion between a medical practitioner and a resident and/or legal representative concerning DNR code status so that an appropriate and timely DNR order was implemented. For R48, the facility failed to ensure that a physician or nurse practitioner discussed DNR code status with the resident and/or the resident's legal representative upon admission to the facility on 5/28/19. R48 had an acute medical emergency at the facility on 6/2/19 and Emergency Medical Services (EMS) personnel responded. The facility failed to show proper DNR code status paperwork when requested by EMS personnel. The facility's failure to coordinate, document and implement R48's DNR code status in accordance with the facility's DNR policy and procedure and Title 16 of the Delaware Code, Chapter 25, was identified as an Immediate Jeopardy (IJ) on 7/11/19 at 3:44 PM. IJ was abated on 7/12/19 at 2:30 PM. Additionally, for two (R1 and R14) current residents with DNR orders, the facility failed to ensure the State DMOST form, also indicating the same DNR status, was signed by the physician in accordance with State law and facility policy. For one (R8) a current resident, the facility failed to ensure the physician had a discussion with the resident or legal representative in accordance with facility policy and State law before writing a DNR order. Findings include: The facility's policy and procedure entitled Do Not	F 678	F678 A. R48 expired on 6/2/19 due to complicated medical condition. R8 - NP documented a note regarding discussion with resident involving wishes for DNR status on 7/11/19. R14 - NP signed resident's DMOST and documented a note regarding discussion with resident's family involving wishes for DNR status on 7/11/19. R1 - NP signed resident's DMOST and documented a note regarding discussion with resident's family involving wishes for DNR status on 7/11/19. B. DON/Designee will audit all active resident records to verify NP/MD documented conversation with resident/family/POA regarding Code Status in the resident medical record. This audit was completed on 7/11/19. Any resident identified that NP/MD has not documented conversation in resident medical record, NP/MD will re-approach resident/family/POA again to have conversation, verify Code Status, document conversation in the medical record and update orders as necessary and this was completed by July 12, 2019. C. The Root Cause of the identified area of concern is that NP/MD required education on the Do Not Resuscitate (DNR) policy indicating that the NP/MD would document conversation with resident and/or family regarding wishes for code status. We are going to	

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F 678	Continued From page 17 Resuscitate (DNR), last revised on 5/2015, stated, "Policy. Cardiopulmonary resuscitation (CPR) is administered to any resident suffering a cardiac or respiratory arrest, unless that resident has a 'do not resuscitate (DNR)' order. A DNR order is permitted if the resident or his/her legal representative has discussed the ramifications with their physician or nurse practitioner as allowed per state regulations and the physician or nurse practitioner has placed the appropriate order in the resident's medical record. A DNR order does not permit the facility to refrain from sending the resident to the hospital if, in the professional staff's opinion they cannot provide needed care for the resident. PROCEDURE: ...If a resident does not wish to receive CPR, the resident or staff member must inform his/her attending physician or nurse practitioner. ...The resident's legal representative can inform the physician or nurse practitioner if the resident is incapacitated or unable to make his/her wishes known. ...The attending physician or nurse practitioner must discuss with the resident and/or family and/or legal representative what a DNR order involves. ...Any legal representative deciding on a DNR must base the decision on the resident's wishes, including the resident's religious and moral beliefs; or, if the resident wishes are not known, in the resident's best interest. ...The attending physician or nurse practitioner must then write a DNR order and a progress note in the resident's medical record. NOTE: the state designated DNR form will suffice as the progress note. ...The progress note must state that the DNR was	F 678	coordinate with discharging facility regarding resident's code status. Once resident is admitted, we will confirm the code status with resident and/or family and document per policy. The Do Not Resuscitate (DNR) Policy will be reviewed again by the NP/MD and this was done by July 12, 2019. The DON/Designee will in-service licensed nursing staff on the Do Not Resuscitate (DNR) policy and this education was completed July 12, 2019, D. The DON/Designee will audit new admissions to ensure that the Code Status orders follow our policy. These audits will be conducted weekly until we reach success for 6 consecutive weeks, then twice monthly until we reach success for 2 consecutive months, then once a month until we determine 100% compliance has been achieved. Outcomes of these audits will be reported at the Quarterly QAPI Committee Meeting for review and recommendation as indicated.	

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F 678	Continued From page 18 requested and that the physician or nurse practitioner discussed the DNR order with the resident or the resident's legal representative." Review of Title 16 of the Delaware Code, Chapter 25 Health-Care Decisions, stated, "... Section 2501 Definitions... (b) 'Agent' shall mean an individual designated in a power of attorney for health care to make a health-care decision for the individual granting the power... (h) 'Health-care decision' shall mean a decision made by an individual or the individual's agent... regarding the individual's health care, including: ... (2) Acceptance or refusal of... orders not to resuscitate;... (4) Execution of a DMOST form pursuant to Chapter 25A of this title... Section 2503 Advance health-care directives... (f) An agent shall make a health-care decision to treat, withdraw or withhold treatment on behalf of the patient after consultation with the attending physician... and in accordance with the principal's individual instructions, if any, and other wishes to the extent known to the agent... Section 2508 Obligations of health-care provider (a) Before implementing a health-care decision made for a patient, a supervising health-care provider, if possible, shall promptly communicate to the patient the decision made and the identity of the person making the decision. The decision of an agent...does not apply if the patient objects to the decision to remove life-sustaining treatment, providing that the objection is (1) by a signed writing or (2) in any manner that communicates in the presence of 2 competent persons, 1 of whom is a physician...Chapter 25A Delaware Medical Orders for Scope of Treatment Act... (c)... (DMOST) means a clinical process to facilitate communication between healthcare professionals and patients... The process encourages shared,	F 678		

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informed medical decision-making. The result is a DMOST form, which contains portable medical orders that respect the patient's goals for care in regard to the use of CPR and other medical interventions... (e)...(1) Is used on a voluntary basis... (3) Is not valid unless it meets the requirements for a completed DMOST form as set forth in this chapter... (4) Is intended to provide direction to emergency care personnel regarding the use of emergency care and to health-care providers regarding the use of life-sustaining treatment by indicating the patient's preference concerning the scope of treatment, the use of specified interventions... (7) Must be signed by a health-care practitioner...".

The Delaware Basic Life Support Protocols, Guidelines and Standing Orders for Prehospital and Interfacility Patients by the Delaware Office of Emergency Medical Services (EMS) and the Delaware Health and Social Services Division of Public Health, effective 1/1/19, stated, "...Current guidelines for do not resuscitate orders...Do Not Resuscitate Order (DNR)...Delaware Medical Orders for Life Sustaining Treatment (DMOST). A DMOST form is a medical order sheet based on the person's current medical condition and wishes...The DMOST form will clearly indicate the patient's wishes concerning life-sustaining treatment and CPR...Section B:... (CPR)... Section E: Review of Orders with Patient. Documents that orders were reviewed with patient or their representative...Section F: Signatures. EMS provider must review this section to ensure it is signed by the patient (or their authorized representative) and healthcare provider...".

1. Review of R48's clinical record revealed the

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following:

6/8/17 - A copy of R48's advance directive was in the clinical record. The advance directive stated, "...I designate the following individual as my Agent to make health care decisions for me: ... F2 (Spouse of R48)...I hereby designate additional or successor Agent: ... F3 (Family Member of R48)...
Qualifying Conditions:
Terminally Ill - (selected) Option 3: Do not Prolong Life...
Serious Illness or Frailty - (also selected) Option 1: My Agent will make decisions on my behalf: In the event I have a serious Illness or frailty and I am unable to understand, make or communicate my wishes, I direct that my Agent make all medical decisions on my behalf...".

5/28/19 at 10:25 AM - The hospital Discharge Summary stated, "...Condition at Discharge stable...".

5/28/19 at 12:45 PM - R48 was admitted to the facility for rehabilitation and intravenous (IV) antibiotic therapy status post hospitalization with discharge diagnoses of Subdural Empyema and Frontal Sinusitis.

5/30/19 at 11:45 AM - A Social Service note, written by E17 (SW), stated, "Meeting with resident's spouse, (name) who with resident's permission is signing admission paperwork. Spouse feels resident 'is not herself'. All paperwork completed...He/she has POA (Power of Attorney) with (other family member name) as back up POA. Code status discussed. Spouse states resident wants DNR status, reported to nursing. D/C (discharge) goal uncertain with

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current medical conditioning and physical functioning level...Spouse is at bedside most of day."

5/30/19 at 1:19 PM - A verbal physician's order for DNR from E6 (NP) was entered into R48's electronic clinical record by a nurse. By entering the verbal physician's order for DNR into the electronic clinical record, R48's DNR code status immediately autopopulated into multiple electronic facility documents, including, but not limited to the eMAR, eTAR and Baseline Care Plan.

5/30/19 at 1:36 PM - A History & Physical (H&P) was completed by E5 (Physician). The H&P did not address R48's code status.

6/2/19 at 5:31 AM - The EMS Prehospital Care Report revealed that BLS (Basic Life Support) personnel arrived at the patient (R48) on 6/2/19 at 5:31 AM. The report stated, "...Upon arrival of ALS (Advanced Life Support) and BLS crews Pt (patient) was unresponsive pulse less (sic) and apnic [sic] (not breathing) laying supine (on back) on the floor...Pt was found on floor this morning by Facility staff and pt was unresponsive so they called 911...Facility advised BLS crew that Pt has a DNR however Facility did not have proper DNR paperwork on hand for BLS crew. Pt's (spouse) wished for resuscitation efforts to be initiated by BLS crew. No bystander CPR was being preformed (sic) prior to BLS arrival...".

6/2/19 at 9:11 AM - A late entry nurse's note, written by E19 (RN) stated, "Nurse checked on pt at (midnight)...PT WAS SLEEPING soundly, no s/s (signs/symptoms) distress noted... Visual observation on hall way during the night pt

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sleeping and no s/s distress. Another rounds (sic) done at 3:50 AM and pt was on his/her bed with cpap on. At 4:56 AM upon entering pt room he/she was found on the floor, pt did not respond to verbal commands but had positive faint carotid (neck) pulse/resp. pt respond (sic) lethargically to sternal rub. immediately contacted...911, md, and spouse. 911 arrived, spouse and...(family member) present. Police officer onsite...Medics MD pronounced pt without signs of life...".

6/4/19 at 10:12 AM - E6 (NP) electronically signed the verbal physician's order for R48's DNR that was entered on 5/30/19 at 1:19 PM.

6/7/19 - The facility's investigation of R48's death on 6/2/19 failed to identify that R48 had an incomplete DNR code status at the time of the acute medical emergency. The facility failed to identify that R48's incomplete DNR code status was not completed in accordance with the facility's DNR policy and procedure and Title 16 of the Delaware Code, Chapter 25.

7/10/19 at 7:37 AM - During an interview, E19 (RN) stated that at 4:56 AM, he/she entered R48's room with IV antibiotic medication to administer. E19 stated that R48's right side upper body was leaning against the bed and R48's lower body was on the floor with all the bed linens/blankets underneath him/her. E19 stated that he/she called for help, performed a sternal rub, and checked R48's pulse which was faint. E19 stated R48 was lethargic. E19 stated that he/she lowered R48 to the floor, stepped out of the room and asked E20 (CNA) to stay with R48. E19 stated that he/she called 911, F2 (R48's spouse), E2 (DON) and the on-call physician. E19 stated, "And before I even called 911, F2

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asked me 'Is somebody coming? Is somebody coming?'" E19 stated, "Yeah, help is on the way, help is on the way. Because I had to put papers together. I assigned the other nurse and the cna to be there in that room." E19 stated that F2 came immediately and phoned F3 (R48's family member) from R48's room. E19 stated that upon arrival, EMS personnel asked to see the document to make sure R48 was a DNR. E19 stated that he/she told them verbally. E19 stated that he/she printed everything and showed them the eMAR and eTAR, which stated DNR. E19 stated that EMS personnel were given a bunch of documents to show them proof that R48 had the status of a DNR. E19 stated that the documents were: plan of care, face sheet, doctor's H&P, eMAR and eTAR. E19 stated that the EMS personnel asked F2 (R48's spouse) if he/she wanted CPR as F2 was present in the room. E19 stated that F2 said yes. E19 stated that EMS personnel proceeded to give R48 CPR and then a short while later they pronounced him/her. E19 stated that he/she knew R48 was a DNR because he/she reviewed the eMAR/eTAR when the resident was admitted to the facility. E19 stated that was the first thing he/she looked at "because you never know, anything could happen".

7/10/19 at 12:56 PM - During an interview, E6 (NP) confirmed that he/she gave the verbal physician's order for DNR status for R48. When asked if he/she wrote any progress notes in R48's clinical record, E6 stated "no" after reviewing the electronic clinical record. When asked if he/she had any discussion about code status with R48 and/or R48's family, E6 stated "no."

7/11/19 at 8:38 AM - During an interview, E17

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F 678	Continued From page 24 (SW) confirmed that he/she had a code status discussion with F2 (Spouse). E17 stated that F2 (Spouse) wanted a DNR code status for R48. E17 stated he/she could not remember who he/she told, probably the nursing supervisor. E17 stated that nursing passes the information on to the Physician/NP. When asked what the procedure was for DNR code status, E17 stated that the Physician/NP meets with the resident/family and has a conversation and then documents the code status in the clinical record and enters a physician order. 7/11/19 at 9:26 AM - During an interview, E5 (Physician) stated that R48's spouse (F2) was not present during the History & Physical on 5/30/19. E5 stated that he/she did not want to have the code status discussion since the family was not present and he/she left R48's code status section blank on the 5/30/19 History & Physical. 7/11/19 at 2:10 PM - During a telephone interview, E22 (RN) stated that between 5 and 5:30 AM he/she went into R48's room to see what was happening. E22 stated that no one else was in the room. E22 stated that he/she did not see R48 on the bed and went further into the room and saw R48 on the floor in between the two beds. E22 stated that he/she observed R48's lips were blue, hands were cold, able to move his/her fingers, and checked R48's brachial (arm) and carotid (neck) pulses. E22 stated there was no pulse. E22 stated he/she went to look for E19 (RN) and found E19 returning to the room (in conflict with E19's [RN] interview on 7/10/19 when E19 stated that he/she asked E20 [CNA] to stay with R48 prior to leaving the room to make calls). E22 stated that E19 told him/her that he/she called 911 and F2 (R48's spouse). E22 stated the	F 678		

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next thing F2 arrived and E22 was trying to console F2, who was crying. E22 stated that F3 (R48's family member) arrived and was on the floor kissing R48 and crying. E22 stated that it took EMS personnel some time to arrive. E22 stated that EMS personnel asked about code status and E19 told them R48 was a DNR. E22 stated that F2 asked EMS Personnel to revive R48.

7/11/19 from 3:44 PM to 4:22 PM - A meeting was held with E16 (ED), E1 (NHA), E2 (former DON), E3 (acting DON) and the survey team. The survey team informed the facility that an Immediate Jeopardy was identified and involved R48 and the facility's failure to complete R48's code status in accordance with the facility's DNR policy and procedure and Title 16 of the Delaware Code, Chapter 25. The facility MD/NP failed to have a sit down discussion with R48's spouse (POA) to determine his/her code status wishes for R48, what the selected code status entailed and a written progress note of the code status discussion.

7/11/19 at 6:41 PM - A meeting was held with E1 (NHA), E2 (former DON), E3 (acting DON) and E6 (NP). The survey team identified 3 additional residents (R1, R8 and R14) currently in the facility that had incomplete code status documentation in their clinical records. The facility also conducted an audit of all the current residents and acknowledged that there were incomplete code status issues with some residents.

7/11/19 at 7:31 PM - The facility submitted a Plan of Correction to the survey team. The facility's NP, E6, was inserviced on the facility's DNR policy and procedure immediately. E6 then

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started working on the code status for the 3 residents identified by the survey team as having incomplete code status documentation. The facility started inservicing the nursing staff on the DNR policy and procedure.

7/11/19 from 7:37 PM to 8 PM - E6 (NP) spoke with either the resident/legal representative/POA to discuss each resident's advance directives. E6 wrote progress notes in each resident's clinical record documenting the discussion, the code status and then entered new physician's orders for each residents' code status.

7/12/19 at 12:35 PM - E5 (Physician) was inserviced on the facility's DNR policy and procedure as he/she signed and dated a copy of the facility's DNR policy and procedure.

7/12/19 at 2:30 PM - The facility completed the nursing staff inservices on the facility's DNR policy and procedure. The facility's Immediate Jeopardy was abated at this time.

The facility failed to have an effective system to coordinate, document and implement DNR code status for R48 in accordance with the DNR policy and procedure and Title 16 of the Delaware Code, Chapter 25. The facility failed to have a process in place that guaranteed a discussion between a medical practitioner and a resident and/or legal representative concerning DNR code status so that an appropriate and timely DNR order was implemented.

7/15/19 at 12:30 PM - Findings were reviewed with E1 (NHA), E2 (former DON), E3 (acting DON), E6 (NP) and E16 (ED) during the Exit Conference.

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F 678	Continued From page 27 7/11/19 from 4:30 PM to 5:45 PM - A review of all current residents in the facility, totaling 43, revealed incomplete code status documentation in the following 3 residents' (R1, R8 and R14) clinical records: 2. R8's clinical record revealed a 2/1/19 History & Physical that noted R8 was a Full Code. A 2/28/19 physician progress note stated, "...Advance Directives: will discuss with family...". A prescriber written physician's order, dated 3/4/19, stated, "DNR - Rn (sic) May pronounce an (sic) release body." R8's clinical record lacked evidence of a 3/4/19 physician progress note. A 3/29/19 physician progress note stated, "...Examination findings...patient...alert and coherent and quite articulate...plan...Patient is a DNR." Although R8 had a DNR physician's order present, the physician's progress notes lacked evidence of a DNR discussion between the physician and R8 and/or legal representative in accordance with the facility's DNR policy and procedure and Title 16 of the Delaware Code, Chapter 25. 7/15/19 at 12:30 PM - Findings were reviewed with E1 (NHA), E2 (former DON), E3 (acting DON), E6 (NP) and E16 (ED) during the Exit Conference. 3. R14's clinical record revealed a DMOST form signed by R14's POA and dated 1/21/19. In Section B, R14's POA selected "Do not attempt resuscitation". The DMOST form was not signed by a physician in Section F. While R14 had a physician's order, dated 1/18/19, which stated, "DNR/DNH/DNI, see DMOST on chart", R14's	F 678		

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F 678	Continued From page 28 DMOST form was incomplete and invalid when the form was not signed by a physician and remained present in R14's clinical record. 7/15/19 at 12:30 PM - Findings were reviewed with E1 (NHA), E2 (former DON), E3 (acting DON), E6 (NP) and E16 (ED) during the Exit Conference. 4. R1's clinical record revealed a DMOST form signed by R1's POA and a Hospice Nurse on 3/22/19, which was the same day that R1 elected Hospice benefits. In Section B, R1's POA selected "Do not attempt resuscitation". The DMOST form was not signed by a physician in Section F. While R1 had a physician's order, dated 3/25/19, which stated, "DMOST/DNR/see resident records", R1's DMOST form was incomplete and invalid when the form was not signed by a physician and remained present in R1's clinical record. 7/15/19 at 12:30 PM - Findings were reviewed with E1 (NHA), E2 (former DON), E3 (acting DON), E6 (NP) and E16 (ED) during the Exit Conference.	F 678		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.	F 684		8/30/19

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F 684	Continued From page 29 This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for two (R42 and R44) out of six (6) residents sampled for medication review, and for one (R48) out of one (1) resident sampled for death review, the facility failed to administer medications as ordered and/or transcribe physician's orders. Findings include: 1. Review of R42's clinical record revealed: 6/14/19 - A physician's order was written for R42 to receive the antipsychotic medication Olanzapine 2.5 mg daily. 6/28/19 - A physician's order was written for R42 to now receive Olanzapine 2.5 mg every other day x (times) five (5) doses. Review of the eMAR revealed R42 received the Olanzapine 2.5 mg on 6/28/19, 6/30/19, 7/2/19, and 7/4/19 for a total of four (4) doses. The facility failed to administer the fifth dose of Olanzapine on 7/6/19 as per physician's orders. Review of the hand written physician's order sheet revealed that although a 24 hour chart check was signed as completed, the facility failed to identify an error in transcribing the order onto the July 2019 eMAR. 7/8/19 approximately 5:00 PM - Findings were reviewed with E2 (former DON). 7/15/19 approximately 12:30 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (former DON), E3 (acting DON), E6 (NP), and E16 (ED). 2. Review of R44's clinical record revealed the	F 684	F684 A. MD was notified for R42 regarding the missed 5th dose of Olanzapine and resident is no longer receiving medication. MD was notified of extra held doses for R44. R48 no longer resides in facility. B. All residents currently residing in Willowbrooke Court at Country House have the potential to be impacted by the identified area of concern. C. A Root Cause analysis was completed on the identified area of concern and it was determined that further education would be required on the Physician Orders Nurse Verification policy to ensure that new orders are properly transcribed and carried out. Licensed Nurses will review physician orders daily and compare written orders to the electronic medical record and complete the 24 hour chart check verification sheet that written orders match the electronic record. The DON/Designee will in-service licensed nursing staff on the Physician Orders Nurse Verification Policy. D. The DON/Designee will randomly audit 10 new written physician medication orders to ensure compliance with policy. These audits will be conducted weekly until we reach success for 4 consecutive weeks, then twice a month until we reach success for 2 consecutive months, then	

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F 684	Continued From page 30 following: 6/5/19 - A physician's order stated for R44 to receive the blood thinning medication Eliquis 2.5 mg twice a day. According to the June 2019 MAR, the Eliquis was timed to be administered at 9:00 AM and 6:00 PM. 7/2/19 10:35 AM - A physician's order was written for R44's Eliquis to be held times two (2) days (48 hours or a total of four (4) doses). Review of the eMAR revealed that the 7/2/19 9:00 AM Eliquis dose had already been given prior to the order being written. Review of the eMAR revealed that the Eliquis was held on: - 7/2/19 at 6:00 PM; - 7/3/19 at 9:00 AM and 6:00 PM; - 7/4/19 at 9:00 AM and 6:00 PM; - 7/5/19 at 9:00 AM. This was a total of three (3) days or six (6) doses held. According to the physician's order, the facility should have resumed administration of the Eliquis on 7/4/19 at 6:00 PM. 7/8/19 2:29 PM - During an interview with E6 (NP) regarding the order to hold Eliquis for 2 days, written on 7/2/19, E6 confirmed that he/she would have expected it to be resumed on 7/4/19 with the 6:00 PM dose. 7/15/19 approximately 12:30 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (former DON), E3 (acting DON), E6 (NP), and E16 (ED). 3. Review of R48's clinical record revealed:	F 684	once a month until we determine 100% compliance has been achieved. Outcomes of these audits will be reported at the Quarterly QAPI Committee Meeting for review and recommendation as indicated.	

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F 684	Continued From page 31 A facility policy and procedure entitled Physician Orders Nurse Verification, last revised on 11/2018, stated, "...To strive to ensure that physician orders are accurately and efficiently entered into the electronic health record application. Procedure: 1. The licensed nurse receiving a hand-written physician order should: a. Carefully verify physician order. b. Enter the physician order into the electronic health record application. 2. In order to double check that orders were not overlooked and are accurate in the electronic application order entry process, within twenty-four (24) hours, a second licensed nurse shall review the hand-written transcribed and newly entered physician orders...3. If a discrepancy in an order is noted, the licensed nurse shall: a. Notify the physician as to the physician order error or omission. b. Transcribe the correct order on the electronic health record application." 5/28/19 - R48 was admitted to the facility. 5/30/19 - A handwritten physician's order by E5 (Physician) stated to administer Myrbetriq medication (reduces bladder spasms) to R48 every night; and to reduce R48's Prednisone (steroid medication to reduce inflammation) to 25 mg every morning. The facility failed to transcribe the 5/30/19 physician's order in R48's electronic health record application. 5/31/19 - Review of R48's 24 Hour Chart Check form, performed on the 11 PM to 7 AM shift, revealed a blank space in the "Initials" column on 5/31/19 where a nurse signs off that it was completed. The facility failed to perform a 24 hour chart check on 5/31/19.	F 684		

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F 684	Continued From page 32 6/1/19 - The handwritten 5/30/19 physician's order revealed a "24 (hour) Chart (check)" was signed and dated by E19 (RN) as completed. Although the 24 Hour Chart Check wasn't completed on 5/31/19, a nurse documented under the written order that he/she reviewed it on 6/1/19, but still did not identify the omission. Review of R48's May 2019 and June 2019 eMARs and Physician Order Recap Report lacked evidence that the 5/30/19 handwritten physician's order was transcribed in the electronic health record application. 7/15/19 at 12:30 PM - Findings were reviewed during the Exit Conference with E1 (NHA), E2 (former DON), E3 (acting DON), E6 (NP) and E16 (ED). The facility failed to transcribe the 5/30/19 physician's orders in R48's electronic health record application; failed to perform the 24 hour chart check on 5/31/19; and failed to identify the omission of the 5/30/19 physician's orders during a 24 hour chart check on 6/1/19.	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on clinical record reviews, interviews, and	F 689	F689	8/30/19

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F 689	Continued From page 33 review of facility documentation as indicated, it was determined that for two (R26 and R43) out of four (4) residents sampled for accidents, the facility failed to ensure that adequate supervision and assistance was provided to prevent accidents. For R43, the facility failed to complete a Physical Therapy (PT) evaluation post fall on 10/22/18 and failed to ensure that R43 was not left alone while toileting on 4/9/19. R43 fell when left alone in the bathroom and sustained a skin tear to the top of his/her right hand. For R26, despite a care plan for 2 - person transfer assist, an unsafe 1-person stand/pivot transfer was performed when R26 fell from the bed to the wheelchair on 2 occasions. R26 had another fall when R26's bed was not in the lowest position. Additionally, the facility failed to ensure adequate supervision and failed to follow R26's toileting plan when R26 fell while being assisted by his/her spouse off the toilet in the bathroom. R26 had 11 falls in 4 months from February through June 2019. Findings include: 1. Review of R43's clinical record and facility documents revealed the following: 10/22/18 - The facility's Incident Report stated, "...in gym with fitness instructor. While transferring from w/c (wheelchair)...lost his/her balance and hit his/her head...". The facility's Quality Assurance Report, dated 10/23/18, stated that as part of the corrective action, a PT evaluation would be completed. Review of the clinical record, including PT notes, lack evidence of a therapy evaluation being completed after R43's 10/22/18 fall.	F 689	A. R43 has a current At Risk for Falls plan of care in place with appropriate interventions and was evaluated by therapy on 1/17/19 (after chart review this evidence was in clinical record) related to falls and C.N.A. involved in incident where resident was left unsupervised on toilet received a counseling/coaching. R26 has a current At Risk for Falls plan of care in place with appropriate interventions and an appropriate transfer status as recommended by a licensed Physical Therapist. Additionally, R26 Kardex viewed by C.N.A.s now indicates instructions for transfer status and bed in low position. Spouse was educated not to transfer resident without requesting assistance from staff. B. The DON/Designee will audit resident care plans to ensure that transfer status, bed height (if applicable) are reflected in the resident's Kardex and when applicable, resident should not be left unattended during toileting. The DON/Designee audited falls that occurred in the month of July to ensure that residents that required PT screening as a fall intervention were carried out. C. A Root Cause analysis was completed on the identified area of concern and it was determined that the C.N.A.s need to review the resident's Kardex prior to providing care to ensure they have knowledge of the appropriate transfer status, bed height (if applicable) and other applicable safety interventions.	

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F 689	Continued From page 34 4/3/19 through 4/6/19 - R43 was hospitalized. 4/6/19 approximately 3:00 PM - R43 was readmitted to the facility. 4/7/19 3:19 PM - A Rehabilitation Note stated, "DOR (Director of Rehabilitation) asked by charge nurse to assist in establishing transfer status for resident. Current recommendation is for resident to use Hoyer lift with all transfers at this time. Resident is unsafe to perform standing transfers or ambulate until further assessment is completed. Resident and CNA agreeable to recommendation." 4/9/19 7:30 AM - A Rehabilitation Note stated, "PT eval (evaluation) completed 4/8/19, recommend continuing with Hoyer lift at this time and having resident use WC for all mobility on and off unit." 4/9/19 6:40 PM - A progress note stated, "Writer was called...to find resident sitting on his/her bottom with back towards wall facing toilet...Resident noted with skin tear to top of right hand measure (sic) at 1.5 cm...". 4/9/19 - A written statement, completed by E21 (CNA), stated R43 was transferred to the toilet and R43 stated he/she wanted to sit for a few minutes to have a bowel movement. E21 wrote that he/she left the resident and went down the hall to get some wipes. E21 wrote that by the time he/she returned, R43 "had attempted to get up even after I had told him/her to wait for me and not to get up before leaving the room, he/she had agreed." 4/10/19 - The facility's investigation stated,	F 689	Additionally it was determined that the Interdisciplinary Team had not identified that a PT screen intervention had been carried out. The DON/Designee will in-service C.N.A.s to review resident's Kardex prior to providing care to ensure knowledge of transfer status, bed height (if applicable) and other applicable safety interventions. The DON/Designee will inservice the Interdisciplinary Team to ensure that new interventions indicating PT Screens are carried out. D. The DON/Designee will conduct audits of resident incidents involving falls to ensure that new interventions are updated as appropriate in the resident's Kardex and those requiring PT Screens will have evidence of a completed PT Screen. These audits will be conducted weekly until we reach success for 4 consecutive weeks, then twice monthly until we reach success for two consecutive months, then once a month until we determine 100% compliance has been achieved. Outcomes of these audits will be reported at the Quarterly QAPI Committee Meeting for review and recommendations as indicated.	

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F 689	Continued From page 35 "...Resident was transferred to the toilet using the full mechanical lift (Hoyer lift) and 2 person assist. Lift was removed from in front of the resident to give more space to provide care. New CNA left resident to get wipes in the hall, when he/she returned the resident was on the floor. The resident appears to have attempted to self transfer and lost his/her balance and fell to the floor...The CNA was given extensive education on not leaving a resident in the bathroom without supervision and to make sure he/she has all necessary supplies prior to toileting/transferring a resident." 7/8/19 approximately 4:45 PM - Findings were reviewed with E2 (former DON). 7/8/19 4:53 PM - During an interview, E15 (OT) stated that anyone requiring a Hoyer lift transfer usually had poor standing and/or sitting balance. E15 agreed that R43 should not have been left unsupervised on the toilet on 4/9/19. The facility failed to ensure that a PT evaluation was completed post fall on 10/22/18, and failed to ensure that R43 had adequate supervision on 4/9/19. Instead, facility staff left the resident alone in the bathroom when he/she attempted to self transfer resulting in a fall and a skin tear. 7/9/19 approximately 8:15 AM - During an interview, E1 (NHA) and E2 (former DON) provided documentation of a PIP (Performance Improvement Plan) and stated that they self identified having issues with falls in the facility. They stated that although they continue to have resident falls, they have not had a fall due to a resident being left alone in the bathroom since R43's 4/9/19 fall.	F 689		

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F 689	Continued From page 36 7/15/19 approximately 12:30 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (former DON), E3 (acting DON), E6 (NP), and E16 (ED). 2. Review of R26's clinical record revealed the following: R26 was admitted to the facility on 1/25/18 with diagnoses including legal blindness, dementia with behavioral disturbance, difficulty walking, and a history of falling. A fall risk care plan was initiated on 1/27/18 identifying that R26 was a fall risk related to a history of falls, leg pain and weakness. Interventions included: - Anticipate and meet the resident's needs. - Be sure the call light is within reach and encourage the resident to use it for assistance as needed ...Prompt response to all requests for assistance. - Ensure that the resident is wearing appropriate footwear when ambulating (walking) or mobilizing in wheelchair. - Needs a safe environment with even floors, free from spills and/or clutter; adequate glare-free light; a working and reachable call light, the bed in a safe position for transfers with wheels locked, personal items within reach. - Remind the resident to request assistance for all transfers and mobility. - Ensure bed height is lowered to appropriate level for safe exit/entry and not too high to reduce risk of serious injury. 2/1/18 - The admission MDS assessment stated that R26 was moderately cognitively impaired	F 689		

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F 689	Continued From page 37 (decisions poor; cues/supervision required), required extensive assist of one staff person for transfers, and had no falls since admission. 2/12/18 - R26's care plan for bladder incontinence was developed related to dementia and impaired mobility with interventions including staff should supervise and offer toileting every 2 hours during waking hours and check and change as needed due to occasional incontinence. 1/22/19 - A Nursing fall risk evaluation score was high risk at 16. 1/23/19 - A Significant change MDS assessment revealed that R26 was severely impaired and exhibited rejection of care with worsening verbal and physical behaviors. R26 required two+ staff person extensive assist for transfers and had 2 falls without injury. 2/1/19 - A care plan intervention on the problem ADL (Activities of Daily Living) self care performance deficit was added indicating the need for 2 person assist at times to transfer and move in bed. Review of R26's fall incident/investigation reports, nursing progress notes, physician orders and fall care plan interventions from February through June 2019 revealed the following: Fall # 1 2/24/19 at 12:00 PM - R26 fell during a transfer from the bed to a chair with assist from his/her CNA and obtained an abrasion on the left knee. The IDT (Interdisciplinary Team) who reviews falls, noted for PT to screen the amount of	F 689		

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F 689	Continued From page 38 assistance appropriate for safe transfers for R26. R26 required 2+ persons for transfers according to his/her significant change MDS, dated 1/23/19. There was no evidence that PT screened R26 after his/her fall on 2/24/19. The facility failed to follow the care plan for 2 person transfer. Fall # 2 3/10/19 at 8:45 PM - R26 stated he/she fell out of bed. R26 was trying to transfer himself/herself and was found on the floor on his/her left side. R26's bed was not in the lowest position. R26 was last observed at 8:30 PM resting in bed. Interventions added after the fall included adhering to R26's toileting schedule every 2 hours, offer hipsters, fall mats beside the bed and a pharmacy review. The facility failed to follow R26's care plan for appropriate lowered bed height for safe exit/entry. 3/11/19 - A PT screen status post fall documented that R26 presented at his/her baseline level and they recommended two person assist for transfer needs for resident and staff safety. 4/15/19 - A PT quarterly screen indicated no skilled services were warranted at this time ...continue to recommend 2 person transfers. Anti rollbacks were recently applied on the wheelchair and the wheelchair brakes were tightened. 4/17/19 - A quarterly MDS assessment stated that R26 remained severely cognitively impaired and he/she continued to exhibit rejection of care. R26 required two+ staff person extensive assist for transfers. Since the prior assessment on 1/23/19, R26 had three falls, two falls without injury and one fall with minor injury.	F 689		

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F 689	Continued From page 39 4/18/19 - The following care plan interventions were initiated, " ...staff to toilet and offer to return to bed for nap at mid - morning, continues to be insistent on performing own tasks and adhering to his/her preferences and self propels in wheelchair back to his/her room regardless of staff redirection." 4/19/19 - A Nursing fall risk evaluation score remained high risk at 14. Fall # 3 5/1/19 at 11:07 AM - R26 slid to the bathroom floor while being assisted off the toilet by his/her spouse. "R26 had sock on only." A CNA (E25) witness statement summary documented that the last time R26 was cared for or toileted was on the 11-7 shift. E25 stated, "Resident was in bed prior to shift change and during rounds. Was with another resident when spouse stopped me in the hall stating that resident was on the floor. Did not witness fall but notified the nurse ...he/she was in the bathroom on the floor in front of the toilet." The fall investigation worksheet documented "safety education to spouse and footwear - non skid socks to be in place". There was no evidence indicating that R26 was asleep during E25's rounds. The facility failed to follow R26's toileting care plan for staff to supervise and offer toileting every 2 hours during waking hours and check and change as needed for occasional incontinence. 5/1/19 at 4:15 PM - A PT screen post fall recommended when staff were assisting that the arm rest of the wheel chair be removed and the bed leveled to the chair to minimize the loss of R26's center of gravity and minimize muscular demand as opposed to the bathroom where a	F 689		

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railing was available and R26's stability was greater.

5/1/19 - The following care plan interventions were initiated, " ...continue toileting schedule, monitor for non skids socks when not wearing shoes, 2 person transfer and staff to remove arm rest when able for stand pivot transfer."

5/1/19 - The CNA Kardex documented "2 person transfers - and staff to remove arm rest when able for stand pivot transfer ...ensure proper footwear when out of bed and gripper socks when in bed ...staff to provide more assistance with dressing, personal hygiene and toileting needs now ...keep bed at lowest setting when in bed ...obtain and encourage use or wear hip savers."

5/5/19 - The care plan intervention "Offer to lay resident down after meals" was initiated.

5/7/19 - The care plan intervention "Request labs check to r/o (rule out) clinical issue that may add to fall risk" was initiated.

5/28/19 - The care plan interventions "Keep bed at lowest setting when in bed and obtain and encourage the wear of hip savers" were initiated.

Fall # 4
6/9/19 at 7:30 AM - R26 was being transferred from the bed into the wheelchair with stand/pivot transfer when R26 slid to the floor from the wheelchair. Predisposing factor included staff handling and gait imbalance. A witness statement was obtained from the CNA who performed the transfer. The facility fall investigation worksheet revealed that the actual transfer when the fall happened was with one staff person (required

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two). The CNA ADL flowsheet dated 6/9/19 at 11:23 AM documented extensive assist of one person. There was no evidence that two staff person assist was performed during the transfer. Interventions included the Nurse Practitioner was to evaluate for possible labs and a PT evaluation. The facility failed to transfer R26 according to the plan of care.

6/17/19 - A Physician ordered a PT evaluation for the recent fall (6/9/19).

6/21/19 at 6:13 PM - A PT note documented that R26 required extensive assistance of two persons for transfers with a gait belt to help secure R26's safety and stability.

7/9/19 at 2:21 PM - During an interview, E7 (RN) stated that R26 used to ambulate with a walker before his/her increasing left leg pain that caused a decline. R26's increased weakness and agitated behavior made it very difficult for staff during transfers and care. "He/She was seen by rehab and had a transfer status change from one person assist stand pivot turn (stand pivot transfer), to two person extensive assist. Sometimes we use the total hoyer lift or the stand up lift to transfer him from bed to wheelchair or whenever we pick him up from the floor. He/She has a lot of falls. The amount of help needed is very inconsistent depending on his/her mental status and his/her ability to help himself/herself on that particular shift or day."

7/9/19 at 2:46 PM - During an interview, E9 (PT) stated that R26 had multiple falls mostly occurring in his/her room recently. When asked if R26 was a hoyer lift or a stand up lift transfer candidate based on feedback from nursing staff, E9 replied

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that "resident is not a lift (Hoyer and/or Stand Up lift) transfer candidate and that resident can display transfers from wheelchair to bed a low (sic) pivot with intermittent trouble clearing armrest and needs 1-2 person maximum assistance for transfers. E9 also added that the wheelchair armrest be removed and the bed leveled to chair to minimize the loss of his/her center of gravity."

7/9/19 at 3:10 PM - In an interview, E10 (CNA) stated that R26 does not use the call bell and does not ask for help when needing assistance with transfers to the bed or to the bathroom. E10 further stated that another aide would have to come with her when she does morning care because of R26's combative behavior.

7/11/19 at 9:59 AM - E10 (CNA) revealed to the surveyor that, "We use the total hoyer lift when we transfer him/her from bed to the wheelchair because he/she is very heavy. I think it is in our CNA task. That's how we transfer him/her every time I am assigned to take care of him." When asked about monitoring R26 for safety, E10 stated that R26 frequently stays in the activity room or self propels his/her wheelchair in the hallways. Furthermore, E10 stated, "When I see him/her in the hallway, I would ask him/her if he/she wants to use the bathroom, and most of the time he/she would answer, 'No.' If I smell him/her of BM (bowel movement) or urine I will take him/her back to his/her room to change."

The facility failed to ensure that the environment was free from accident hazards when:
- On 2/24/19 at 12:00 PM, R26 had an unsafe transfer from the bed to the wheelchair when one CNA was providing assistance, instead of two

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F 689	Continued From page 43 staff that were required, which resulted in a fall with a left knee abrasion. - On 3/10/19 at 8:45 PM, R26 fell out of bed and the bed was not in the lowest position, despite R26 being at high risk for falls. - On 5/1/19 at 11:00 AM, R26 slid to the bathroom floor while being assisted off the toilet by his/her spouse. R26 was last toileted by the 11-7 shift. The facility failed to follow R26's toileting care plan for staff to supervise and offer toileting every 2 hours during waking hours and check and change as needed for incontinence. - On 6/9/19 at 7:30 AM, R26 had a fall due to an unsafe transfer from the bed into the wheelchair with 1 staff person extensive assist, despite the care plan and rehab recommendation for 2 person extensive assist with transfers. Findings were reviewed with E1 (NHA), E2 (former DON), E3 (Acting DON), E6 (NP), and E16 (ED) during the Exit Conference on 7/15/19 at approximately 12:30 PM.	F 689		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).	F 725		8/30/19

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F 725	Continued From page 44 §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on interviews and review of facility documentation, it was determined that the facility failed to have sufficient nursing staff with the appropriate skills to ensure that all residents received needed care and services. Findings include: 1. Resident Council Meeting minutes reviewed from January 2019 through June 2019 stated: 1/21/19 - "...Old Business: Medicines not being given on time. Weekends are not good, some miss breakfast since they are the last to get up...". 2/19/19 - "...Nursing: Call light time is still ongoing for all three shifts. The water is not being filled on a regular basis. Beds are not being made in the am shift...". 3/18/19 - "...New Business:...A. Beds are still not being made. B. The water is being filled. This concern is resolved. C. Call light response time is	F 725	A. Due to the fact that Residents identified wished to remain anonymous, we are unable to correct the identified area of concern for those particular individuals. Dates cited on this 2567 (6/30, 7/1, 7/5 and 7/6) the facility was staffed at a PPD exceeded the State required minimum staffing levels. Additionally it should be noted that the facility has not received a State Level tag for not maintaining minimum required staffing levels and our CMS Star Rating for Staffing has been and remains currently at 5 stars. B. The DON/Designee will meet with Alert and Oriented Residents who do not routinely attend Resident Council meeting to determine if there are any concerns that care needs are not being met. C. A Root Cause analysis was completed on the identified area of concern and it	

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F 725	Continued From page 45 improving...improved to 20 minutes and all shifts improved. This concern is resolved...". 5/30/19 - "...Nursing...Resident sat 40 minutes before call bell got answered...Several residents are waiting for their aide to come and put them to bed after resident lunch...". 6/6/19 - "...Nursing...Various residents discussed concern about call bell response time and shower preference...". 6/24/19 - "...Call Bell response time still seems to be a general area of concern with most residents. The weekends tend to be worse than the week time...". 2. A surveyor conducted Resident Council Meeting was held on 7/3/19 at approximately 10:30 AM. There were 17 (A4 through A20) residents present. When asked "Do you get the help and care you need without waiting a long time? Does staff respond to your call light timely?" Eleven (A4 through A8, A10, A13, and A15 through A19) out of the 17 residents stated that they do not always get the help and care they need without waiting a long time. They stated that they have had to wait 20 to 60 minutes at times. 3. The facility's Alarm (call bell) Response Report was reviewed for 6/30/19, 7/1/19, 7/5/19, and 7/6/19. The report revealed the following: 6/30/19 - The response time to R12's call bell was 22 minutes and 2 seconds; 6/30/19 - The response time to R37's call bell was 24 minutes and 17 seconds; 6/30/19 - The response time to R42's call bell was 21 minutes and 28 seconds; 6/30/19 - The response time to R248's call bell	F 725	was determined that the facility would need to reinforce licensed nurses and C.N.A.s to carry pager devices while on duty so that staff are notified when a call bell has been activated and assist so their care needs can be met. A member of the Nursing Management team will attend Resident Council Meeting monthly to address concerns. The DON/Designee will in-service licensed nurses and C.N.A.s that pagers will be carried during their shift and that call bells are to be responded to promptly. D. The DON/Designee will randomly interview 5 residents weekly to inquire about satisfaction or dissatisfaction with call bell response time and follow-up with staff as appropriate. These audits will be conducted weekly until we reach success for 4 consecutive weeks, then twice monthly until we reach success for two consecutive months, then monthly until we determine 100% compliance has been achieved. Additionally, resident council minutes will be audited to ensure that there is appropriate follow-up to call bell response/care need concerns. These audits will continue monthly for until we reach success for three consecutive months or until 100% compliance has been achieved. Outcomes of these audits will be reported at the Quarterly QAPI Committee meeting for review and recommendation as indicated.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 46 was 25 minutes and 51 seconds; 7/1/19 - The response time to R42's call bell was 37 minutes and 50 seconds; 7/5/19 - The response time to R7's call bell was 21 minutes and 5 seconds; 7/5/19 - The response time to R6's call bell was 21 minutes and 15 seconds; 7/6/19 - The response time to R37's call bell was 21 minutes and 37 seconds. 4. Interviews during the survey with five (A1, A2, A3, A4, and A5) residents and one family member (F4), all who wished to remain anonymous, revealed the following: A. 7/1/19 10:00 AM - During an interview, A1 stated that he/she waits a "long time." A1 stated that "yesterday (Sunday) I sat for one hour and 15 minutes waiting to go to the bathroom." A1 stated this occurred around 1 PM to 2:15 PM. A1 stated that he/she was very wet, that weekends are the worst. A1 stated he/she spoke with a nurse (did not identify who), who ended up toileting him/her and changing his/her clothes. A1 also stated that the nurse responded, "you know there are problems here." B. 7/1/19 10:39 - During an interview, A2 stated that he/she has had to wait approximately 30-45 minutes for staff to respond on the 11 PM to 7 AM shift. C. 7/2/19 10:52 AM - During an interview, A3 and F4 (family member) stated that A3 has had to wait 45 minutes for staff to respond to the call bell for assistance to go to the bathroom. A3 and F4 stated that this occurred yesterday (Monday) at approximately 3:50 PM. A3 and F4 stated that it took staff approximately 40 minutes to respond.	F 725		

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	085003	A. BUILDING _____ B. WING _____	C 07/15/2019

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F 725	Continued From page 47 F4 was angry and stated, "this is not acceptable." D. 7/3/19 11:05 AM - During an interview, A4 stated that there have been times during the 11 PM to 7 AM shift when he/she has had to wait an hour before their call bell was answered. E. 7/2/19 10:00 AM - During an interview, A5 stated that the facility was understaffed and that it takes 20 to 25 minutes for staff to respond to call lights. A5 stated it was especially bad on weekends across all three (3) shifts. The facility failed to have sufficient nursing staff to meet the needs of all residents. 7/15/19 approximately 12:30 PM - Findings were reviewed with E1 (NHA), E2 (former DON), E3 (acting DON), E6 (NP), and E16 (ED).	F 725		
F 730 SS=D	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on facility document review and interview, it was determined that the facility failed to complete an annual performance review for one (E20) out of five (5) CNAs reviewed. Findings include: Review of E20's employee documents revealed:	F 730	F730 A. E20's Annual Performance Review has been completed. B. The DON/Designee will audit active employee listing for staff working on	8/30/19

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F 730	Continued From page 48 3/8/18 - E20's date of hire. There was no annual performance review provided by the facility for E20. 7/15/19 8:55 AM - During an interview, E4 (ADON) confirmed there was no performance review for E20. 7/15/19 approximately 12:30 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (former DON), E3 (acting DON), E6 (NP), and E16 (ED).	F 730	Willowbrooke Court of Country House to ensure Annual Performance Review has been completed based on their hire date and if any annual performance reviews are found to be out of compliance, they will be brought into compliance. C. A Root Cause analysis was completed on the identified area of concern and it was determined that the ADON and Nurse Supervisor who were responsible for completing Annual Performance Reviews will require additional in servicing on how to properly track due dates of annual performance reviews utilizing an electronic performance review tracking system. The DON/Designee will in-service the ADON and the Nurse Supervisor on utilizing the HALOGEN Performance Review Management Software to track and complete annual performance evaluations for C.N.A.s timely. D. The DON/Designee will conduct weekly audits of the HALOGEN Performance Review Management Software to ensure that annual performance reviews for C.N.A.s are being conducted timely. This audit will be conducted once weekly until we reach success for 4 consecutive weeks, then twice a month until we reach success for 2 consecutive months, then once a month until we determine 100% compliance has been achieved. Outcomes of these audits will be reported	

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F 730	Continued From page 49	F 730	at the Quarterly QAPI Committee meeting for review and recommendation as indicated.	
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced	F 755		8/30/19

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F 755	Continued From page 50 by: Based on clinical record review, interview and review of facility documentation as indicated, it was determined that for one out of one death record review, the facility failed to provide routine pharmaceutical services to meet the needs of R48. Findings include: The facility pharmacy's policy entitled "LTC Facilities: Receiving Pharmacy Products and Services from Pharmacy", last revised on 1/2/13, stated, "...Procedure... 3. The pharmacy will provide new routine and PRN medication orders the same day, unless the medication would be started until the next day. " 5/28/19 - The hospital's Medication Orders Upon Discharge stated to administer to R48 the following medications: - Advair (inhaler) twice a day, "Next Dose Due: tonight 5/28"; - Lacosamide (anti-seizure) twice a day, "Next Dose Due: tonight 10 PM 5/28"; - Seroquel (antipsychotic) at bedtime, "Next Dose Due: tonight 5/28 10 PM". 5/28/19 at approximately 12:00 Noon - R48 was admitted to the facility. 5/28/19 - R48's physician Order Recap Report also stated that Calcium-Vitamin D (dietary supplement) and a nasal spray were ordered. 5/28/19 - Review of R48's May 2019 eMAR and corresponding Order-Administration Notes revealed: - R48 did not receive Advair, Lacosamide, Seroquel, Calcium-Vitamin D and nasal spray at 8 PM as the facility was waiting for the pharmacy	F 755	A. R48 no longer resides at the facility. B. The DON/Designee will audit a new orders listing report for current residents to identify new orders for medications and will ensure that medications have arrived and were administered as ordered. C. A Root Cause analysis was conducted on the identified area of concern and it was determined that licensed nursing staff did not locate the delivered medication and did not call the pharmacy to confirm medication was delivered. Going forward, licensed nurses will call the pharmacy to confirm delivery of medications when nurse is unable to locate a medication that has been prescribed. If pharmacy confirms medication was delivered, licensed nurse will conduct a secondary search for medication. If medication is not located, licensed nurse will contact pharmacy again and request another delivery. The DON/Designee will in-service licensed nursing staff on the procedures related to delivery and receipt of routine pharmacy deliveries and procedures relating to the receipt of emergency medication deliveries. D. The DON/Designee will audit resident medical records for appropriate follow-up of missed medication due to unavailability and ensure proper procedures were followed. These audits will be conducted daily until we reach success for 3	

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F 755	Continued From page 51 to deliver the medications. - At 8:58 PM, R48's Advair was discontinued by E6 (NP) for a generic equivalent medication, Breo Ellipta (inhaler), for a diagnosis of asthma. Despite a pharmacy interchange order that was sent to the facility on 5/28/19 at 9 PM for Breo Ellipta, the physician's order stated to start the medication on 5/30/19. It was unclear in R48's clinical record why the Breo medication was ordered to start on 5/30/19 and not 5/29/19. 5/29/19 at 1:27 AM - The pharmacy's Proof of Delivery report for R48 revealed that Lacosamide, Seroquel, nasal spray, Breo Ellipta, and Calcium with Vitamin D were delivered to the facility at this time. 5/29/19 - Review of R48's May 2019 eMAR and corresponding Order-Administration Notes revealed: - At 8:45 PM - An Order-Administration Note, written by E24 (RN), for R48's Lacosamide stated, "...Not delivered yet from (name) pharmacy." Despite having received the Lacosamide medication from the pharmacy on 5/29/19 at 1:27 AM and R48 receiving her 8 AM dose, R48 was not administered the medication at 8 PM. 7/11/19 at 9:26 AM - During an interview, E5 (Physician) stated he/she was told about R48's missing doses of his/her seizure medication at a later time. 7/11/19 at 12:30 PM - Findings were reviewed during the Exit Conference with E1 (NHA), E2 (former DON), E3 (interim DON) and E6 (NP). The facility failed to provide routine pharmaceutical services to meet the needs of	F 755	consecutive days, then three times a week until we reach success for three consecutive weeks, then once weekly until we reach success for three consecutive weeks, then once a month until we determine 100% compliance has been achieved. Outcomes of these audits will be reported at the Quarterly QAPI Committee meeting for review and recommendation as indicated.	

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F 755	Continued From page 52 R48.	F 755		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in	F 758		8/30/19

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F 758	Continued From page 53 §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on clinical record reviews and interviews, it was determined that for one (R42) out of six (6) residents sampled for medication review the facility failed to ensure R42's PRN Lorazepam (anti-anxiety medication) physician's order was limited to 14 days or the clinical record had evidence of the prescriber's rationale to extend the PRN order beyond 14 days and the duration for the PRN order. Findings include: Review of R42's clinical record revealed the following: 6/11/19 - The original physician's order was written for R42 to receive Lorazepam as needed for anxiety/agitation. 6/24/19 - An order was written to renew R42's PRN Lorazepam for seven (7) days. 7/2/19 - An order was written to renew R42's PRN Lorazepam for 14 days. The facility failed to ensure that when the PRN Lorazepam orders were renewed on 6/24/19 and	F 758	A. R42 no longer has an order for a PRN Psychotropic Medication. B. The DON/Designee will audit current residents residing on Willowbrooke Court to identify residents with orders for PRN Psychotropic medications and ensure that MD /NP has documented rationale for continued use of PRN Psychotropic medication in the resident medical record. C. A Root Cause analysis of the identified area of concern was conducted and it was determined that the MD/NP would require further review of the policy on Psychotropic Medications as it relates to prescribing PRN Psychotropic Medications beyond 14 days. The DON/Designee will in-service the Nurse Practitioner and the Medical Director on the Psychotropic Medication policy. D. The DON/Designee will conduct an	

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F 758	Continued From page 54 7/2/19 for R42, a corresponding note documenting the rationale to extend the medication was not completed by the prescribing practitioner. 7/8/19 approximately 5:00 PM - Findings were reviewed with E2 (former DON). 7/15/19 approximately 12:30 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (former DON), E3 (acting DON), E6 (NP), and E16 (ED).	F 758	audit of residents on PRN Psychotropic Medications to ensure that if the MD/NP continues use beyond 14 days, the NP/MD has documented rationale for continued use. This audit will be conducted weekly until we reach success for 4 consecutive weeks, then twice monthly until we reach success for two consecutive months, then once a month until we determine 100% compliance has been achieved. Outcomes of these audits will be reported at the Quarterly QAPI Committee meeting for review and recommendation as indicated.	
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on clinical record review, interviews and review of facility documentation as indicated, it was determined that for one out of one death record review, the facility failed to ensure that R48 was free of any significant medication errors. R48 missed an 8 AM dose of an intravenous (IV) antibiotic, Ceftriaxone, on 5/30/19 due to the facility not having enough IV tubing equipment on hand to administer the medication. Despite the facility receiving "Stat" (immediately) IV tubing from the pharmacy at 12:38 PM, the facility retimed R48's next dose for 6 PM, which resulted in a further delay of treatment. R48 received the next dose at 6:30 PM, approximately 6 hours	F 760	F760 A. R48 no longer resides in the facility. B. DON/Designee will audit current residents residing in Willowbrooke Court at Country House to identify residents who are receiving IV Antibiotics and ensure that IV tubing is available. C. A Root Cause analysis of the identified area of concern was conducted and it was identified that the facility had not hung the IV antibiotic timely due to IV tubing that	8/30/19

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F 760	Continued From page 55 after the "Stat" IV tubing was delivered. Findings include: The facility's pharmacy policy entitled LTC Facilities: Receiving Pharmacy Products and Services from Pharmacy, last revised on 1/2/13, stated, "...Procedure ...4. The pharmacy will provide "stat" medication orders that are not available in the facility's emergency drug supply within one hour of the time ordered during normal pharmacy hours...". Review of R48's clinical record revealed: 5/28/19 - The hospital's Medication Orders Upon Discharge for R48 stated to administer Ceftriaxone intravenously every 12 hours. 5/28/19 at approximately 12 Noon - R48 was admitted to the facility for IV antibiotic therapy status post hospitalization with diagnoses of subdural empyema, osteomyelitis and frontal sinusitis. 5/28/19 - A physician's order stated to administer Ceftriaxone IV two times a day for subdural empyema, osteomyelitis and frontal sinusitis. 5/30/19 at 8 AM - Review of R48's May 2019 eMAR revealed that the resident's IV antibiotic, Ceftriaxone, was not administered at 8 AM. 5/30/19 at 8:56 AM - A nurse's note stated, "NP (E6) made aware of missing IV tubing. Pharmacy called and new IV tubing to be sent out STAT." 5/30/19 at 12:38 PM - The pharmacy's Proof of Delivery record revealed that R48's IV tubing was received by the facility at 12:38 PM.	F 760	was supplied by pharmacy had been used and facility had not maintained a supply of IV tubing to be used as backup for residents. A supply of IV tubing will be maintained at the facility. The DON/Designee will in-service the Unit Clerk and the Administrative Assistant to ensure that the facility maintains a supply of IV tubing. D. The DON/Designee will audit availability of IV Tubing. This audit will conducted weekly until we reach success for 4 consecutive weeks, then twice monthly until we reach success for 2 consecutive months, then once a month until we determine 100% compliance has been achieved. Outcomes of these audits will be reported at the Quarterly QAPI Committee meeting for review and recommendation as indicated.	

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F 760	Continued From page 56 5/30/19 at 2:08 PM - An Order-Administration Note for R48's IV antibiotic Ceftriaxone stated, "...Waiting for pharmacy." 5/30/19 at 2:41 PM - A nurse's note stated, "...Unable to give 0900 (9 AM) abt. (antibiotic) DR (doctor) made aware. Tubing arrived. Dosage schedule has changed...". Despite the delivery of the "Stat" IV tubing at 12:38 PM according to the pharmacy's record, the facility did not administer R48's IV antibiotic. 5/30/19 at 6 PM - R48's May 2019 eMAR revealed that the timing of the resident's IV antibiotic was changed from 8 AM and 8 PM to 6 AM and 6 PM. 5/30/19 at 6:30 PM - An Order-Administration Note revealed that R48 received the IV antibiotic. The facility delayed R48's IV antibiotic treatment 6 additional hours after the "Stat" IV tubing was delivered to the facility. 7/10/19 at 9:03 AM - During an interview, E2 (former DON) stated that the hospital sent R48's discharge information to the facility on Friday, 5/24/19. E2 stated that E4 (ADON) reviewed everything to ensure the facility had everything in place for R48 before he/she was admitted on Tuesday, 5/28/19. E2 stated that the pharmacy provided all IV equipment, including the IV pump, IV tubing and IV medication. 7/10/19 at 2:36 PM - During a combined interview with E2 (former DON) and E4 (ADON), when asked about the missing IV antibiotic dose due to the lack of IV tubing available, E2 confirmed that the facility should have had an emergency	F 760		

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F 760	Continued From page 57 backup of IV tubing and he/she had addressed this with the pharmacy. E4 stated that the pharmacy told her the delivery would be in 4 hours for the "Stat" request. 7/11/19 at 12:30 PM - Findings were reviewed during the Exit Conference with E1 (NHA), E2 (former DON), E3 (interim DON) and E6 (NP). The facility failed to ensure that R48 was free of any significant medication errors when R48 missed an 8 AM dose of an IV antibiotic on 5/30/19 due to the facility not having enough IV tubing equipment on hand to administer the medication. Despite the facility receiving "Stat" IV tubing from the pharmacy at 12:38 PM, the facility retimed R48's next dose for 6 PM, which resulted in a further delay of treatment. R48 received the next dose at 6:30 PM, approximately 6 hours after the "Stat" IV tubing was delivered.	F 760		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (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.	F 812		8/30/19

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	085003	A. BUILDING _____ B. WING _____	C 07/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOKE COURT AT COUNTRY HOUSE	**4830 KENNETT PIKE WILMINGTON, DE 19807**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 58 §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, it was determined that the facility failed to properly prepare, store, and serve food in a sanitary manner. Findings include: During the kitchen inspection on 7/1/19 from 11:00 AM - 12:00 PM, it was observed that the floor tiles and grout throughout the facility were in disrepair. The holes in the corner of walls from the broken tiles will create opportunities for pests to infest the kitchen. Furthermore, it was observed that the ceiling tiles at the food service area were greasy and porous. The ceiling must be easily cleanable to reduce contamination from daily wear and tear. Findings were reviewed and confirmed with E18 (Food Service Director) on 7/1/19 at approximately 12:00 PM. Findings were reviewed with E1 (NHA) on 7/3/19 at approximately 3:00 PM.	F 812	F812 A. The facility will obtain a work order and commit with a contractor by 8/30/19 to repair ceiling tiles and floor tiles. B. All residents currently residing in Willowbrooke Court have the potential to be impacted by the identified area of concern. C. A Root Cause analysis of the identified area of concern was conducted and it was determined that the kitchen floor tiles in disrepair and the ceiling tiles had not been identified during routine rounding. The Plant Operations Manager will create a new Preventative Maintenance Check to be completed by Plant Operations. The new Preventative Maintenance Check will be completed monthly. The NHA/Designee will in-service the Culinary Manager and the Plant Operation Director to complete the monthly Preventative Maintenance check of the floor tiles and ceiling tiles in the main kitchen. D. The NHA/Designee will audit Preventative Maintenance Check to ensure that floor tiles and ceiling tiles are noted to be in good repair. This audit will be conducted monthly until we reach	

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F 812	Continued From page 59	F 812	success for 3 consecutive months. The audit will continue until we determine 100% compliance has been achieved. Outcomes of these audits will be reported at the Quarterly QAPI Committee meeting for review and recommendation as indicated.	
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on reviews of one (R48) death record and 43 current residents' records, interviews and review of facility documentation as indicated, it was determined that the facility's Quality Assessment and Assurance Committee failed to identify a system failure to follow the facility's DNR policy and procedure that was in place since 5/2015 to ensure completion of 7 (R1, R3, R8, R14, R17, R33 and R48) residents' code status. Findings include: Cross refer to F678 Review of R48's clinical record revealed that on 6/2/19, R48 had an acute medical event and was found on the bedroom floor at 4:56 AM. Facility staff did not initiate CPR as R48 was a DNR according to what was listed in R48's clinical record. E19 (RN) called 911 emergency services	F 867	F867 A. R48 no longer resides in the facility. B. Any resident currently residing in the facility has the potential to be impacted by the identified area of concern. C. A Root Cause analysis of the identified area of concern was conducted and it was determined that through the QAPI process, the team had not identified concerns with Code Status as it pertains to MD/NP written documentation of conversation regarding Code Status. QAPI will include review of 1 closed record quarterly. The DON/Designee will in-service	8/30/19

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WILLOWBROOKE COURT AT COUNTRY HOUSE	4830 KENNETT PIKE WILMINGTON, DE 19807

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F 867	Continued From page 60 at 5:13 AM and EMS personnel responded. Despite E19 stating that R48 was a DNR and showing multiple documents to EMS personnel, the facility failed to have the proper DNR paperwork on hand for EMS personnel. The facility's failure to complete R48's code status according to the facility's DNR policy and procedure was identified as immediate jeopardy (IJ) on 7/11/19 at 3:44 PM. Review of all current residents' clinical records in the facility, as of 7/11/19, revealed that 6 (R1, R3, R8, R14, R17 and R33) out of 43 residents had incomplete code status documentation. 7/11/19 at 6:41 PM - A meeting was held with E1 (NHA), E2 (former DON), E3 (interim DON) and E6 (NP). The survey team identified 6 additional residents currently in the facility that had incomplete code status documentation in their clinical records. The facility also conducted an audit of all the current residents and acknowledged that there were incomplete code status issues with some residents. 7/12/19 at 11:10 AM - During a combined interview with E1 (NHA), E2 (former DON) and E3 (interim DON), when asked if the facility identified a system failure with respect to code status, E1 stated that the QAA Committee talked about having a code status for each resident during QAA meetings. However, E1 stated that the QAA Committee never identified an issue with code status, specifically the failure to follow the facility's DNR policy and procedure. E1 stated that the QAA Committee never developed an official performance improvement plan for code status.	F 867	members of the QAPI Committee on the Quality Assurance performance improvement and compliance program as it relates to the identification of areas of concern. D. The NHA/Designee will audit Quarterly QAPI Committee minutes to ensure that review of closed record was completed. This audit will be conducted quarterly for one year to ensure that 100% compliance has been achieved. Outcomes of these audits will be reported at the Quarterly QAPI Committee meeting for review and recommendations as indicated.	

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F 867	Continued From page 61 7/15/19 at 12:30 PM - Findings were reviewed with E1 (NHA), E2 (former DON), E3 (interim DON) and E6 (NP) during the Exit Conference. The facility's Quality Assessment and Assurance Committee failed to identify a system failure to follow the facility's DNR policy and procedure that was in place since 5/2015 to ensure completion of code status' for 7 residents.	F 867		
F 881 SS=D	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on record review, interview and review of facility policy, it was determined that the facility failed to ensure the appropriate use of an antibiotic for one (R42) out of six (6) residents sampled for medication review. Findings include: The facility policy titled "Antibiotic Stewardship," last revised 10/2017, stated "...Ensure nursing staff access, monitor and communicate changes in a resident's condition in accordance with a standardized criteria, such as McGreer for residents in long-term care...In collaboration with the medical director help ensure antibiotics are prescribed only when appropriate...". The facility policy titled "Antibiotic Usage," last	F 881	F881 A. R44 is no longer on a Antibiotics. B. The DON/Designee will audit current residents residing on Willowbrooke Court to identify residents who are currently receiving Antibiotics to ensure the Antibiotic is justified based on UA C&S lab results. C. A Root Cause analysis of the identified area of concern was conducted and it was determined that the need to continue the antibiotic after receipt of the UA C&S lab results was not re-evaluated by the	8/30/19

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F 881	Continued From page 62 revised 7/09, stated "...1. The licensed nurses and Infection control coordinator/preventionist will review culture reports upon receipt from the laboratory. 2. The physician will be notified via phone and/or fax of all culture reports...". Review of R44's clinical record revealed the following: 6/5/19 - R44 was admitted to the facility post hospitalization. 6/5/19 through 6/6/19 - Review of progress notes revealed that R44 did not have any complaints of pain or discomfort or any elevated temperatures. 6/6/19 - A physician's order stated to obtain a urinalysis (UA) and C&S. It is unclear what prompted the order to obtain the urine specimen, as there was no progress note regarding the issue. 6/7/19 - The UA results were reported stating that R44 had blood in the urine and some bacteria. 6/7/19 - A physician's order stated to start the antibiotic Macrobid 100 mg twice a day for ten (10) days for a urinary tract infection pending the C&S report. 6/8/19 - The urine C&S was reported from the laboratory and revealed that there was no growth after 24 hours, otherwise stating that R44 did not have a urinary tract infection. There was no documented evidence that the physician was notified of the urine C&S results. 6/10/19 - Review of the urine C&S laboratory report sheet revealed it was noted as reviewed on	F 881	Interdisciplinary Team to prompt a reassessment of the ongoing need for the choice of the antibiotic or discontinuation. The DON/Designee will in-service the Assistant Director of Nursing, and the Nurse Manager to ensure that lab results for residents receiving antibiotics are reviewed and communicated to the physician to ensure appropriate continued use or discontinuation of antibiotic. D. The DON/Designee will audit residents with new orders for antibiotics to ensure that lab results were obtained and reviewed with physician to determine continued use or discontinuation. This audit will be conducted weekly until we reach success for 4 consecutive weeks, then twice monthly until we reach success for 2 consecutive months, then once a month until we determine 100% compliance has been achieved. Outcomes of these audits will be reported at the Quarterly QAPI Committee meeting for review and recommendation as indicated.	

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

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

STATE SURVEY REPORT

NAME OF FACILITY: WillowBrooke Court at Country House DATE SURVEY COMPLETED: July 15, 2019

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced Annual, Complaint and Emergency Preparedness survey was conducted at this facility from 7/1/19 through 7/15/19. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census the first day of the survey was 43. The survey sample was 34.		
3201	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.0	**Scope**		
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:** Cross Refer to the CMS 2567-L survey completed July 15, 2019: F550, F580, F622, F661, F678, F684, F689, F725, F730, F755, F758, F760, F812, F867, and F881.	Please Cross reference CMS 2567 POC for Ftag's F550, F580, F622, F661, F678, F684, F689, F725, F730, F755, F758, F760, F812, F867, and F881.	8/30/19

Provider's Signature Robert Sh. Title NHA Date 8/12/19