STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08A020	A. BUILDING _____ B. WING _____	07/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEWARK MANOR NURSING HOME	254 WEST MAIN STREET NEWARK, DE 19711

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced annual survey was conducted at this facility from June 25, 2019 through July 1, 2019. The facility census the first day of the survey was 65. During this period an Emergency Preparedness Survey was also conducted by the State of Delaware's Division of Health Care Quality Long Term Care Residents Protection in accordance with 42 CFR 483.73. For the Emergency Preparedness survey no deficiencies were cited.	E 000		
F 000	INITIAL COMMENTS An unannounced annual survey was conducted at this facility from June 25, 2019 through July 1, 2019. 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 65. The survey sample totaled thirty seven (37) residents. Abbreviations/definitions in this report are as follows: ADON - Assistant Director of Nursing; ADL - Activities of Daily Living CNA - Certified Nurse's Aide; DON - Director of Nursing; HOH - Hard of hearing; hearing impaired; i.e.-that is, Kardex - a medical information system used by nursing staff as a way to communicate important information about their residents; MAR - Medication Administration Record; MD - Medical Doctor; MDS - Minimum Data Set (standardized assessment form used in nursing homes);	F 000		

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

Electronically Signed | 07/23/2019

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 NHA - Nursing Home Administrator; PASRR 1.5 and Level II - (Preadmission Screening and Resident Review) - screening for signs of serious mental illness and/or intellectual disabilities, developmental disabilities or related conditions so if in a nursing home they receive all necessary services for their condition; RN - Registered Nurse; RNAC - Registered Nurse Assesement Coordinator; TAR - Treatment Administration Record; Antidepressant - medication to treat depression; Anti-psychotic- drug to treat mental/emotional conditions (e.g. Risperdal, Seroquel); gradual dose reduction (GDR) - slowly reducing amount of medication; mg - milligrams-unit of weight; Psychotropic (medication) - medication capable of affecting the mind, emotions and behavior; Seroquel - anti-pychotic medication; Schizophrenia-a long term mental disorder of a type involving a breakdown in thought, emotion,and behavior; Trazodone - medication for depression; Antibiotic - drug to treat bacterial infection; Pneumococcal Immunizations - Pneumonia vaccine; Psychiatric - related to mental disorders; Psychiatrist - physician for treatment of mental disorders; TB - Tuberculosis.	F 000		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and	F 584		8/30/19

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F 584	Continued From page 2 supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility failed to provide a	F 584	A. Residents impacted by loud pages over the intercom during resident council	

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F 584	Continued From page 3 home-like environment with comfortable sound levels in one (the third floor) out of three dining rooms. Findings include: 6/27/19 2:30 PM - 3:15 PM - Observations during the Resident Council Meeting with 11 residents (R44, R30, R20, R45, R3, R15, R61, R53, R48, R4, R8) in attendance in the third floor activities/dining room revealed more than six screeching overhead intercom announcements that were so loud that the group discussion had to stop during these announcements. R44 was observed holding his/her hands over his/her ears during each overhead announcement. E24 (Activities Director) who was present in the beginning and end of this meeting had to stop speaking during these loud overhead announcements. 7/1/19 12:30 PM - During an interview, R15 (Resident Council President) confirmed that the third floor activities/dining room overhead intercom announcements were too loud and very disruptive. Findings were reviewed with E1 (NHA) and E2 (DON) on 7/1/19 during the exit conference beginning at 3:00 PM.	F 584	meeting caused disruption and flow of the meeting and discomfort to residents ears. B. Volume was adjusted immediately to provide a home like environment with comfortable sound levels for the residents. Volume knob was marked to an appropriate volume so that the sound will not be increased above volume indicated. C. A lock box will be placed over each volume control panel to ensure the volume will not be increased above an identified comfort level as indicated by the residents D. Audit will be performed 3 times a week and PRN by Environmental Director and/or designee. Over head sound testing will be performed with a resident in different parts of the building to determine what the resident identifies as a comfortable noise level until 100% for 4 consecutive weeks, then 1 time weekly until 100% for 4 consecutive weeks, then PRN to maintain compliance. Reported findings will be discussed through the QA process F. See attachment #1 (maintenance audit)	
F 585 SS=E	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with	F 585		8/30/19

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F 585	Continued From page 4 respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman	F 585		

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F 585	Continued From page 5 program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement	F 585		

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F 585	Continued From page 6 Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on group resident and staff interviews, observations and review of facility documentation, it was determined that the facility failed to have an established grievance policy or process of having information on how to file grievances anonymously. In addition, the facility's grievance postings failed to list the name and contact information of the Grievance Officer. Facility policy entitled: Resident - Family Concern / Grievance Procedure (signed & approved 12/14/16) did not include the following required information: - notification of postings in prominent locations throughout the facility of the right to file grievances orally or in writing; - the right to file grievances anonymously; - the contact information of the grievance official with whom a grievance can be filed; - the right to obtain a written decision regarding his or her grievance; - the contact information of independent entities with whom grievances may be filed, i.e. State Agency, Ombudsman. March - May 2019 - Review of the Resident Council meeting minutes revealed no evidence regarding information on how to file an anonymous grievance. This process was not discussed with the residents.	F 585	A. Residents were not aware of how to file grievances anonymously. Residents were not supplied with grievance officers name and contact information on the grievance postings throughout the building. The facility admission packet did not identify the grievance office or how to anonymously file a grievance. B. Policy adjusted to include the right to file grievances anonymously, the contact information of the grievance official with whom a grievance can be filed, the right to obtain a written decision regarding his or her grievance, the contact information of independent entities with whom grievances may be filed, i.e. State Agency, Ombudsman. Postings posted throughout the facility stating the grievance officer and how to submit a grievance, also lock box have been purchased and will be located in areas throughout the facility for anonymous grievances to be placed. All residents and resident representatives will be provided a copy via email or mail of the revised grievance policy and procedure to file a concern or grievance. C. Lock boxes have been purchased and	

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F 585	Continued From page 7 6/27/19 2:30 PM - During the Resident Council Meeting, when asked if they knew how to file an anonymous grievance, the 11 residents (R44, R30, R20, R45, R3, R15, R61, R53, R48, R4, R8) attending the meeting answered "no." 6/27/19 4:30 PM - Review of the facility's admission packet revealed no information on filing an anonymous grievance or contacting the grievance officer. 7/1/19 11:15 AM - During an interview, E4 (RN, Social Services) confirmed that the policy was missing the above listed requirements, there was no system in place to ensure residents can file a grievance anonymously and the facility did not have postings with information on how to file an anonymous grievance or the grievance officer with contact information. Findings were reviewed with E1 (NHA) and E2 (DON) on 7/1/19 during the exit conference beginning at 3:00 PM.	F 585	will be installed on each floor in a residents area at a wheelchair accessible location. Lock boxes will be checked on a weekly basis for grievances and addressed by the grievance officer. The grievance officer will provide a written or verbal response within 10 days of receiving the grievance to the resident or resident representative upon request.. If the concern or grievance is related to abuse, exploitation, misappropriation of resident property, mistreatment, neglect, sexual abuse etc. appropriate state/federal agencies will be notified and reported to DLTCRP. Residents and resident representative will be contacted once concern or grievance has been addressed to determine if they are satisfied with the resolution. If the resident/resident representative is satisfied this will be indicated on the concern log, If the resident/resident representative is dissatisfied with the plan and the facility is unable to resolve the concern or grievance other options will be offered such as The Ombudsman or DLTCRP. The admission packet has been updated stating how residents and resident representatives can submit a grievance or concern anonymously and supplied with grievance officers name and contact information. Residents will also be notified at the resident council meeting about who the grievance officer is and where a grievance or concern can be reported. D. The lock box will be checked on a weekly basis, all grievances will be	

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F 585	Continued From page 8	F 585	monitored and resolved as described. The grievance officer will attend the next 4 resident council meetings that occur every fourth Wednesday during each month to introduce self, explain the grievance policy and the location of the lock box for anonymous grievances or concerns to be reported. On going, the Activities Director will announce who the grievance officer is and how to file an anonymous concern or grievance at the beginning of every Resident Council Meeting. Activities Director will add the name and contact information of grievance officer to personal index cards located in each residents room. All anonymous grievances or concerns that have been rectified will be discussed during the resident council meeting maintaining confidentiality. An Activities Director and/or designee will conduct a random audit to ensure all the personal index cards are present and accounted for, who the grievance officer is and how and where to file a grievance until 100% for 4 consecutive weeks, then 1 time weekly until 100% for 4 consecutive weeks, then PRN to maintain compliance. All reports of grievances will be reported through the QA process F. See attachment #2 (Grievance Policy) G. See attachment #3 (Admission Packet) H. See attachment #4(Grievance Audit) 1. See attachment #5(Personal Index Card)	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments.	F 641		8/30/19

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F 641	Continued From page 9 The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to ensure an annual MDS assessment was accurate for one (R37) out of 37 residents sampled for investigations. Findings include: Review of R37's clinical record revealed the following; 11/6/18 - An annual MDS assessment, in the area for Medications, documented R37 as not having received antipsychotic medications since admission, entry, reentry or the prior assessment. November 2018 - Review of R37's MAR revealed that R37 was receiving an antipsychotic at that time for "behaviors" since 6/9/18. During an interview on 6/27/19 at 3:31 PM with E9 (RNAC) it was confirmed there was an error in the area of Medications on R37's 11/6/18 annual MDS Assesement. Findings were reviewed with E1 (NHA) and E2 (DON) on 7/1/19 during the exit conference beginning at 3:00 PM.	F 641	A. Resident annual MDS assessment section N was inaccurately documented for antipsychotic medications, although resident was in fact receiving an antipsychotic medication for behaviors since 6/9/18. B. Annual MDS for November 2018 resident R37 was corrected and resubmitted for accuracy. C. Before locking the MDS, the MDS Coordinator will recheck section N for any medications missed/inaccurately documented prior to locking and submitting the MDS. The MDS will be rechecked for accuracy by DON before submission. D. MDS Coordinator will perform audits on all residents listed on the scheduled MDS list for accuracy of section N before locking and submitting for 100% compliance for three consecutive months. The following three months three residents will be chosen randomly each month to be audited for accuracy of MDS in comparison to the MAR until 100% compliance is achieved. An audit will be done for one random resident each month times three months for 100% compliance. Reported findings will be discussed through the QA process. See attachment #6(MDS Audit)	

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F 644	Continued From page 10	F 644		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for one (R12) out of one resident reviewed for Preadmission Screening and Resident Review (PASRR) the facility failed to make a referral to the state authority when a newly evident mental disorder was identified. Findings include: Review of R12's clinical record revealed: 4/12/18 - A PASRR 1.5 was completed and revealed that R12's diagnosis does not meet the criteria for a serious mental illness and R12 does not require a Level II PASRR.	F 644	A. Resident R12 was without updated Preadmission Screening and Resident Review (PASRR). The facility failed to make a referral to the state authority when a newly evident mental disorder was identified, B. All resident PASRRs within the facility have been audited for accuracy related to diagnoses and medications. Each resident that needs an updated PASRR will be submitted for review. C. All orders and or consultations will be reviewed and reported by ADON and/or	8/30/19

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F 644	Continued From page 11 4/19/18 - R12 was admitted to the facility. 6/21/19 - A quarterly MDS revealed an active diagnosis of Schizophrenia. 7/1/19 - A care plan listed "OTHER SCHIZOPHRENIA" as a diagnosis. 7/1/19 10:58 AM - During an interview E4 (RN) confirmed that the facility did not refer R12 for PASRR review when the newly evident mental disorder was identified. Findings were reviewed with E1 (NHA) and E2 (DON) on 7/1/19 during the exit conference beginning at 3:00 PM.	F 644	MDS coordinator to Social Services and/or Designee. Any change in residents current diagnosis or medication will prompt Social Services and/or Designee to submit for an updated PASRR. D. All resident PASRRs will be aduited weekly with any medication changes and/or added medical diagnosis and sent to state authorities for review if necessary. Social Services and/ or designee will conduct a random audit until 100% for 4 consecutive weeks, then 1 time weekly until 100% for 4 consecutive weeks, then PRN to maintain compliance. Reported findings will be discussed through the QA process. See attachment #7(PASRR Audit)	
F 685 SS=D	Treatment/Devices to Maintain Hearing/Vision CFR(s): 483.25(a)(1)(2) §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R312) out of one	F 685	F685 - A. Residents physicians order, care plan	8/30/19

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F 685	Continued From page 12 sampled resident reviewed for hearing/vision, it was determined that the facility failed to ensure that R312 received proper treatment and assistive device to maintain hearing abilities. Findings include: Review of R312's clinical record revealed: 5/31/19 - Resident was admitted to the facility from the hospital with a diagnosis of HOH (Hard of Hearing). 5/31/19 - A baseline careplan completed at admission identified R312's hearing impairment and that R312 uses hearing appliances. 5/31/19 - An admission summary note documented that R312 " is HOH and wears aides. L (left) is currently broken and family is in the process of fixing..." 5/31/19 - The CNA (Certified Nurse Aide) Kardex stated under resident care that R312 is HOH 6/3/19 - A physician order documented to place hearing aide to right ear every morning and to place right hearing aid in the case at the bedside every evening. Order was timed in the evening shift for hearing impairment. 6/3/19 - Another physician order documented to place hearing aide in right ear every morning and to place right hearing aid in the case at the bedside every evening. Order was timed for 8:00 in the morning shift for hearing impairment. 6/3/19 - A care plan was developed for ADL (Activities of Daily Living) self - care deficit related to limited mobility... with a goal for R312 to	F 685	and task was updated to reflect nurse and/or aide to place hearing aide in right ear every morning upon residents request. Nurse will offer hearing aide in the morning with medication administration. Nurse will confirm hearing aid placement prior to signing off on physician's order. Nurse and/or aide to place right hearing aid in case at bedside every evening shift. The nurse will confirm hearing aids are placed in case prior to signing off on physician's order. The resident has specific care plan created to reflect hard of hearing and the use of assistive device. B. All other residents physicians orders, care plans and tasks who use hearing assistive devices were audited to ensure residents hearing aids are being placed in the residents ear and documented correctly. C. Instructions on placement of hearing device was not clear nor specific for nursing staff. During each resident care plan meeting, the ADON and/or designee will review residents physicians orders, task and care plan to identify any resident who is using hearing assistive devices are receiving proper treatment and assistive devices to maintain hearing abilities. An educational in-service will be provided to all staff explaining updated policies and changes made to the care plan as a result of deficient practices. D. ADON and/or designee will conduct an audit for all residents who use hearing	

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F 685	Continued From page 13 maintain current level of function in assisting with care through the review date. Interventions included, "...hearing aid to right ear with charger to remain in room. Left is broke pending replacement (sic)... is HOH..." 6/13/19 - An admission MDS (Minimum Data Set) assessment identified R312 to have adequate ability to hear with hearing aide if normally used and that R312 uses a hearing aid. 6/25/19 at 12:11 PM - During an interview with R312, the resident requested the surveyor to get his/her hearing aide placed inside bedside drawer so he/she can put it on. 6/26/19 at 2:12 PM - When asked if hearing aide was place in right ear, R312 replied "No, they keep them. Not been using it a lot lately..." No hearing aide was observed in R312's right ear. Observations revealed no hearing aide was noted placed on R312's right ear on 6/26/19 at 4:28 PM and on 6/27/19 at 9:55 AM respectively. 6/27/19 at 4:41 PM - In an interview, E4 (RN/Social Worker) stated that R312 was admitted with hard of hearing and wears right hearing aide as the left one is broken and family is working on it. Further stated that a "...physician order was obtained for the right hearing aide so that the nurses can sign off on it and for the hearing aid to not get lost." 6/28/19 at 8:35 AM - During the interview, E2 (DON) confirmed that E4 documented hard of hearing in the baseline careplan but a person centered careplan on R312's hearing impairment was not developed.	F 685	assistive devices for proper treatment and use ensuring that care plans, tasks, and physician orders are updated. until100% for 4 consecutive weeks, then 1 time weekly until 100% for 4 consecutive weeks then at every care plan meeting and PRN to maintain compliance. Reported findings will be discussed through the QA process. See attachment #8(Hearing Devices Audit)	

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F 685	Continued From page 14 6/28/19 at 8:40 AM - Review of the June 2019 TAR (Treatment Administration Record) revealed that the nurses working in the morning shifts documented placing the hearing aid in R312's right ear at 8:00 every morning. 6/28/19 at 9:59 AM - When asked again about the right hearing aide, R312 stated, "I put it on by myself whenever I think about it - or whenever I remember to put it on." 6/28/19 at 10:06 AM - In an interview, E13 (LPN) stated that, "Resident wears hearing aide to her right ear. Resident is able to put the hearing aide on. The CNA would take the hearing aide from the drawer and offer it to the resident to apply." 6/28/19 at 12:00 PM - During an interview, E14 (CNA) stated, "I offer the hearing aide for R312 to apply to her right ear. Sometimes she refuses to wear it. I can not force her." 6/28/19 at 1:13 PM - During an interview, E6 (Staff Development Coordinator) explained that R312's right hearing aid is kept in his/her drawer for recharging in the evening after being used during the day. E6 further confirmed that the nurses are responsible for putting on the hearing aids as they are signing it off in the treatment administration record and to ensure function and secure placement. The facility failed to ensure that R312 received proper treatment and assistive device to maintain hearing abilities when the facility failed to place the hearing aid in R312's right ear which resulted to R312's difficulty in hearing when his/her right hearing aid was not in use and not checked for	F 685		

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F 685	Continued From page 15 placement during the survey observation period. During exit conference on 7/1/19 at approximately 3:00 PM, findings were reviewed with E1 (NHA) and E2 (DON).	F 685		
F 730 SS=E	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 interview and review of facility documentation, it was determined that the facility failed to ensure performance evaluations were completed at least every 12 months for four (E14, E19, E20 and E22) out of five sampled CNAs and that the facility failed to provide the required in-service training based on the outcome of the CNA's performance review for one (E21) out five CNAs sampled. Findings include: 6/29/19 1:30 PM - During an interview, E6 (Staff Educator, LPN) stated the facility did not have a policy for CNA performance evaluations. 7/1/19 10:00 AM - The latest performance evaluations for five randomly selected CNAs were provided by E3 (ADON) and reviewed by the surveyor. The following was revealed: - E14 (CNA) was hired on 6/9/15. The latest performance review was dated 3/15/19, but not	F 730	A. Facility failed to ensure the CNA performance evaluations were completed at least every 12 months and to reflect education on weaknesses indicated. E21 was not provided with education in regards to weakness indicated. Performance evaluations were not signed by both employee and supervisor for the following employees E14, E19, E20 and E22. B. E21 has received in-service training based on the outcome of her performance evaluation. All CNA's performance evaluations were reviewed to ensure supervisor and employee have signed the performance evaluations. Education will be provided to all CNA's in regards to their identified weaknesses. Performance evaluations will be created online in Google Forms to be completed	8/30/19

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F 730	Continued From page 16 signed by the employee or the supervisor who wrote the evaluation. - E19 (CNA) was hired on 5/16/17. No supervisor performance review was provided by the facility. A self-evaluation written by the employee was dated 3/10/19, but not signed by a supervisor. - E20 (CNA) was hired on 3/14/16. The latest performance review was dated 2/26/19, but not signed by the employee. - E21 (CNA) was hired on 2/4/02. The latest performance review was dated 3/1/19 and was signed by both the employee and the supervisor who wrote the evaluation. The supervisor who completed evaluation (E9, MDS Coordinator) identified that E21 needed improvement in engaging more with residents during down time and time management while providing care. - E22 (CNA) was hired on 2/25/86. The latest performance review was dated 2/21/19, but not signed by the employee. 7/1/19 11:00 AM - During an interview, E6 (Staff Educator, LPN) confirmed he/she was not able to provide documentation that E21 (CNA) received education on the above areas identified as needing improvement. The surveyor was unable to determine if the performance evaluations were reviewed with E14 (CNA), E19 (CNA), E20 (CNA) and E22 (CNA) by their supervisors. 7/1/19 1:00 PM - During an interview, E3 (ADON) confirmed the above findings.	F 730	annually by Staff Educator and/or designee. This will ensure all CNA's have performance evaluations conducted in an organized method. The Staff Educator and/or designee and employee will sign acknowledgement forms of completed performance evaluations annually. C. A policy was implemented stating performance reviews will be conducted 90 days after employment and annually thereafter. D. Staff Educator and/or designee will conduct an audit to ensure all employees have an updated Performance Evaluation along with education related to identified weaknesses monthly until 100% for 3 consecutive months, then 1 time quarterly until 100% compliance, then PRN to maintain compliance. Reported findings will be discussed through the QA process. See attachment #9(Performance Evaluation Audit) See attachment #19(Policy for Job Performance Evaluations)	

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F 730	Continued From page 17 Findings were reviewed with E1 (NHA) and E2 (DON) on 7/1/19 during the exit conference beginning at 3:00 PM.	F 730		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly	F 756		8/30/19

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F 756	Continued From page 18 drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to develop a policy that included time frames for all steps of the monthly drug regimen review process and failed to respond to pharmacist recommendations for one (R60) out of five residents reviewed for medication review. Findings include: 1. The facility's policy titled Medication Regimen Review did not include a time frame for the facility to respond to the recommendations of the pharmacist. The facility's policy for Consult Pharmacist Services Provider Requirements (revised November 2018) included: "...Specific activities that the consultant pharmacist performs includes, but is not limited to: -Reviewing the medication regimen of each resident at least monthly, or more frequently under certain conditions... -Communicating to the responsible prescriber and the facility leadership potential or actual problems detected and other findings relating to medication therapy orders including recommendations for changes in medication therapy and monitoring of medication therapy as well as regulatory compliance issues at least monthly..." 2. The following was reviewed in R60's clinical record:	F 756	F756- A. Immediately R60 pharmacy recommendation was addressed by MD and seen by psychiatrist. After each pharmacy recommendation is addressed by MD, a copy will be given to DON for review and follow up for any inappropriate responses. B. The pharmacy recommendations for residents with recommendations were reviewed by the DON for accuracy and completion. All inaccuracies were reported to MD. C. The policy did not reflect a time frame for response to pharmacy recommendations and the providers were not aware on appropriate responses acceptable to CMS for declined GDR's. The medication regimen review policy was updated to reflect a time frame of 30 days for physician to respond to all pharmacy recommendations. The Medical Director for facility, Nurse Practitioner and psychiatrist was educated on appropriate responses, how to address a decline in gradual dose reductions and pharmacy recommendations and the time frame as indicated in attachment #10 Documentation and Communication of Consultant Pharmacist	

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F 756	Continued From page 19 8/27/18 - The Consultant Pharmacist Report recommendations to the physician/prescriber: "Periodic dose reductions of Seroquel should be attempted to establish the lowest effective dose and/or the need to continue treatment. Please consider a gradual dose reduction of Seroquel to 25 mg twice a daily. If a GDR (gradual dose reduction) is contraindicated, please provide rationale, citing specific behaviors or potential risks to resident associated with a GDR." 8/30/18 - Physician/Prescriber Response: Disagree - I do not want to make changes and will provide a brief rationale - "Patient has behavior issues. Will f/u (follow up) in 1 month." 3/28/19 - The Consultant Pharmacist Report recommendations to the physician/prescriber: "Please consider a gradual dose reduction (GDR) of Trazadone if appropriate. This resident has been receiving the current dose of 25 mg twice daily and 100 mg at bedtime for some time now. CMS guidelines require antidepressants to be periodically considered for GDR's to evaluate the lowest effective dose for treatment. If a GDR is contraindicated, please provide rationale, citing specific behaviors or potential risks to resident associated with a GDR." 4/9/19 - Physician/Prescriber Response: Disagree - I do not want to make changes and will provide a brief rationale - "Family does not want to GDR - feels resident currently stable." 5/16/19 - The Consultant Pharmacist Report recommendations to the physician/prescriber: "CMS requires Seroquel to be periodically considered for dose reductions to establish the	F 756	Recommendations. DON reviewed pharmacy recommendations for any inappropriate responses to gradual dose reductions and refer to MD for follow up. D. DON and/or designee will conduct a monthly audit of appropriate responses to pharmacy recommendations until 100% for 3 consecutive months, then every other month until 100% for 2 consecutive audits, then PRN to maintain compliance. Reported findings will be discussed through the QA process. See attachment #10(Drug Review Policy). See attachment #11(Appropriate Response Audit)	

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F 756	Continued From page 20 lowest effective dose and/or the need to continue treatment. Please consider a gradual dose reduction of Seroquel 50 mg twice a daily. If a reduction would be inappropriate, please document such for compliance of nursing home regulations. If a GDR (gradual dose reduction) is contraindicated, please provide rationale, citing specific behaviors or potential risks to resident associated with a GDR." Physician/Prescriber Response (not dated): "Please refer to psychiatry." 7/1/19 9:00 AM - During an interview, E6 (Staff Educator, LPN) confirmed that the prescriber did not followed up in one month on the 8/27/18 recommendation, that the there was not additional justification (than the family wishes) to not follow the 3/28/19 and that the 5/16/19 recommendation was not referred to psychiatry. Findings were reviewed with E1 (NHA) and E2 (DON) on 7/1/19 during the exit conference beginning at 3:00 PM.	F 756		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and	F 761		8/30/19

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F 761	Continued From page 21 Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that for one out of two medication carts, the facility failed to date medications appropriately. Findings include: 6/25/19 11:48 AM - An observation and inspection of the third floor medication cart revealed two opened bottles of liquid oral medications that were untimed and undated. The undated medications expiration dates were 12/12/19 and 6/12/20. This finding was immediately confirmed by E12 (RN). Findings were reviewed with E1 (NHA) and E2 (DON) on 7/1/19 during the exit conference beginning at 3:00 PM.	F 761	A. Facility failed to date and time two open bottles of liquid oral medication appropriately on the third floor medication cart. B. The third floor medication cart was checked for any other medications not dated and timed when opened. All other medication carts in facility were also checked for any medications that were not dated and timed if opened. No undated or untimed medications were found during this review. C. The 11-7 Supervisor and/or designee will check all medication carts for undated/untimed medications weekly. All nurses will be educated on proper procedure when opening medication for first use. D. Day shift charge nurse and/or designee will conduct an audit of all medication	

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F 761	Continued From page 22	F 761	carts to ensure any opened medication is dated and timed for 4 consecutive weeks until 100% compliance , then every other week until 100% for 4 consecutive weeks, then once a month until 100% compliance and then PRN to maintain compliance. Reported findings will be discussed through the QA process. See attachment #12(Dated and Timed medication audit)	
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on a random dining observation it was determined that the facility failed to prepare and serve food in accordance with professional standards for food service safety in one (2nd floor dining area) out of three dining areas. Finding	F 812	A. Facility failed to prepare and serve food in accordance with professional standards for food service safety resulting in cross contamination thus putting the residents in jeopardy.	8/30/19

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F 812	Continued From page 23 include: 1. Observations were made in 2nd floor dining area, during lunch between 12:26 PM and 1:13 PM on 6/25/19: -Wearing gloves, E15 (dietary aide) touched the refrigerator door, milk cartons and then the drinking edge of 3 glasses. Then E15 prepared the beverages and served these glasses to residents. -Wearing clean gloves, E15 touched a cabinet knob and door, then the drinking edge of a glass retrieved from the cabinet. Then E15 poured soda in the glass and served it to a resident. -E15 used the same gloves as above to touch the drinking edge of another glass, poured a house shake in the glass and served it to a resident. 2. Observations were made in 2nd floor dining area, during lunch between 12:15 PM and 1:00 PM on 6/25/19: 6/25/19 12:25 PM - Wearing gloves, E15 (dietary aide) touched a cabinet knob and door and removed a plastic tub from the cabinet. Then, while wearing these contaminated gloves, E15 directly touched the bread several times while making peanut butter and jelly sandwiches. The sandwiches were served by E18 (CNA) to R6. Findings were reviewed with E1 (NHA) and E2 (DON) on 7/1/19 during the exit conference beginning at 3:00 PM.	F 812	B. Food Service Director immediately educated E15 on the importance of food service safety, handwashing and how to avoid cross contamination. All dietary staff were also educated on food service safety, handwashing and cross contamination. Food Service Director observed dietary staff serving meals and corrected any violation of safe food handling. C. Food Service Director and/or designee will randomly monitor different serving areas weekly to ensure dietary staff are complying with safe handling of food while avoiding cross contamination. D. Food Service Director and/or designee will conduct an audit to ensure professional standards and food service safety are being met for 4 consecutive weeks until 100% compliance , then every other week until 100% compliance, then PRN to maintain compliance. Reported findings will be discussed through the QA process. See attachment #13(Food Service Safety Audit)	
F 880 SS=C	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control	F 880		8/30/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08A020	A. BUILDING _____ B. WING _____	07/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEWARK MANOR NURSING HOME	254 WEST MAIN STREET NEWARK, DE 19711

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F 880	Continued From page 24 The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08A020	A. BUILDING _____ B. WING _____	07/01/2019

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F 880	Continued From page 25 involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on review of facility documents and interview it was determined that the facility failed to conduct an annual review of their Infection Control and Prevention Policies, and to update the program as necessary. Findings include: 6/28/19 and 7/1/19 - Review of the Infection Prevention and Control Program policies and procedures revealed: 1. The following policies and procedures had no documented review since signed by E2 (DON) on 11/28/17:	F 880	A. The facility failed to conduct an annual review of our infection control and prevention policies and to update the program as necessary. B. Immediately the Infection Control and Prevention Manual was reviewed and signed by NHA, DON and MD. C. The Infection Control and Prevention Manual is currently in the process of being revised and updated by the Interdisciplinary Team for accuracy and	

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F 880	Continued From page 26 - Assessment of Facility Strengths and Weaknesses to Initiate and Maintain an Antimicrobial Stewardship program; - Engagement of Residents and Family members in Antimicrobial Use; - Establishment of an Antibiotic Stewardship Program; - Measurement of Antibiotic Use and Antibiotic Stewardship Activities; - Microbiology Testing; - Communication of Resident Condition and Treatment with Antimicrobial Orders. 2. The following policies and procedures had no documented review/revision since February 2018: - Infection Reporting System; - Prevention and Control of Tuberculosis; - Infection Control Influenza and Pneumococcal Disease Immunization Program; - Infection Control Recommendations for Employee Health; - Prevention of Blood-Borne Diseases; - Management of Accidental Exposures to Blood-Borne Pathogens. 3. The written protocol for prescribing specific antibiotics was not dated. 7/1/19 11:00 AM - During an interview, E3 (ADON) confirmed that the above policies had not been review/revised in the past year. Findings were reviewed with E1 (NHA) and E2 (DON) on 7/1/19 during the exit conference beginning at 3:00 PM.	F 880	outdated information. Any policy or procedure that requires an update will be revised accordingly with revision date indicated. Once the review and revisions have been made in the Infection Control and Prevention Manual the DON, NHA and MD will sign and date indicating review and revisions have been made. This will occur annually and PRN. D. Infection Preventionist and/or designee will conduct an audit to ensure the Infection Control and Prevention Manual is reviewed and up to date monthly for three consecutive months until 100% compliance, then every three months times two reviews until 100% compliance, then annually and PRN. Reported findings will be discussed through the QA process. See attachment #14(Preface) See attachment #15(Infection Control and Prevention Manual Audit)	

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

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

STATE SURVEY REPORT

NAME OF FACILITY: Newark Manor

DATE SURVEY COMPLED: July 1, 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 survey was conducted at this facility from June 25, 2019 through July 1, 2019. The facility census the first day of the survey was 65. During this period an Emergency Preparedness Survey was also conducted by the State of Delaware's Division of Health Care Quality Long Term Care Residents Protection in accordance with 42 CFR 483.73. For the Emergency Preparedness survey no deficiencies were cited.		
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 the following:** Cross refer to CMS 2567-L survey completed July 1, 2019: F584, F585, F641, F644, F685, F730, F756, F812, F880, F943, and F947.	Dementia Training-3201.5.6 A. E3 and E17 have been in-serviced on Dementia specific training. E16 is no longer employed at Newark Manor. B. All employees who continue to work at the facility will be in-serviced on Dementia Specific Training within 45 days, annually and PRN. C. A policy was not in place enforcing mandatory attendance for all mandated in-service. A policy regarding attendance for mandatory in-services was implemented.	

Provider's Signature _____ Title Administrator Date 7-29-19

NAME OF FACILITY: Newark Manor **DATE SURVEY COMPLED: July 1, 2019**

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
3201.5.6	**Dementia Training** Nursing facilities that provide direct healthcare services to persons diagnosed as having Alzheimer's disease or other forms of dementia shall provide dementia specific training each year to those healthcare providers who must participate in continuing education programs. This section shall not apply to persons certified to practice medicine under the Medical Practice Act, Chapter 17 of Title 24 of the Delaware Code. The mandatory training must include: communicating with persons diagnosed as having Alzheimer's disease or other forms of dementia; the psychological, social, and physical needs of those persons; and safety measures which need to be taken with those persons. This requirement was not met as evidenced by: Based on interview and review of facility documentation it was determined that the facility failed to provide dementia specific training in the past year to three (E3, E16 and E17) out of ten randomly selected healthcare providers reviewed. Findings include: 6/28/19 1:00 PM - During an interview, E6 (Staff Educator, LPN) confirmed that the facility was unable to show documentation that E3 (ADON), E16 (RN) and E17 (LPN) completed dementia specific training in the past year. E3 and E16's most recent dementia training was in 2017. E17 completed dementia training on 6/25/19, but it was after the surveyor requested this	The policy enforces mandatory attendance and disciplinary action for all mandated educational in- services not attended. Employees will be educated on policy and sign off that they have read and understand. D. Ongoing any employee who does not attend a Mandatory educational in-service will be suspended pending completion of mandated in-service. An audit will be performed to ensure compliance of attendance for all mandated education one time a week for four consecutive weeks until 100% compliance, then every 2 weeks times two reviews until 100% compliance, then monthly and PRN. Reported findings will be discussed through the QA process. See attachment #17(Attendance Policy) See attachment #18(In-Service attendance audit)	

Provider's Signature _____ Title _____ Date _____

NAME OF FACILITY: Newark Manor

DATE SURVEY COMPLED: July 1, 2019

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	information on 6/25/19. Findings were reviewed with E1 (NHA) and E2 (DON) on 7/1/19 during the exit conference beginning at 3:00 PM. **Nursing Staffing**		
Chap. 11 Subchapter VII § 1162	Nursing staffing. (a) Every residential health facility must at all times provide a staffing level adequate to meet the care needs of each resident, including those residents who have special needs due to dementia or a medical condition, illness or injury. Every residential health facility shall post, for each shift, the names and titles of the nursing services direct caregivers assigned to each floor, unit or wing and the nursing supervisor on duty. This information shall be conspicuously displayed in common areas of the facility, in no fewer number than the number of nursing stations. Every residential health facility employee shall wear a nametag prominently displaying his or her full name and title. Personnel hired through temporary agencies shall be required to wear photo identification listing their names and titles. This requirement was not met as evidenced by: Based on observation and interview, it was determined that the facility failed to conspicuously display the names and titles of the nursing staff direct caregivers assigned to each unit and the nursing supervisor on duty		

NAME OF FACILITY: Newark Manor

DATE SURVEY COMPLED: July 1, 2019

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	for each shift in common areas of three (First Floor, Second Floor and Third Floor) of the three nursing units. Findings include: 6/25, 6/26, 6/27, 6/28 and 7/1/19 - Observations of the common areas of the three (First Floor, Second Floor and Third Floor) nursing units revealed that the following required information was not included in the staff postings: -which floor the staff are assigned. -the nursing supervisor on duty for each shift. 7/1/19 11:15 AM - During an interview, E3 (ADON) confirmed that the above listed required staffing information was not included in the staff postings and that the postings will be corrected. Findings were reviewed with E1 (NHA) and E2 (DON) on 7/1/19 during the exit conference beginning at 3:00 PM.	Staffing Chap. 11 **Subchapter VII § 1162** A. The facility immediately developed a revised nursing census sheet, adding the location of each working caregiver and identifying the nurse supervisor on duty. B. A revised nursing census sheet was posted on each floor throughout the facility to help identify the location of each working caregiver and nurse supervisor. A family meeting was held on July 18,2019 and those in attendance were made aware of the location of the nursing census sheet and the information provided on it. Resident representatives that were not in attendance will be informed via email of the location of the nursing census sheet and the information provided on it.	

Provider's Signature _____ Title_____ Date _

NAME OF FACILITY: Newark Manor

DATE SURVEY COMPLED: July 1, 2019

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
		C. Facility was not aware of the need to identify the location of working staff members and nurse supervisor. The 11-7 supervisor initiates nursing census sheet every morning, by identifying all nursing staff direct caregivers scheduled to work each day and the location for which they will be working. The 11-7 supervisor will post nursing census sheet in designated areas each morning. An educational in-service will be provided to all staff explaining updated policies and changes made. D. Everyday the nurse supervisor on duty will audit nursing census sheets on each floor at the start of each shift to ensure accuracy of the location of each nursing staff direct caregiver and nurse supervisor on duty. Nurse supervisor will initial each census sheet ensuring accuracy for location of staff.. This is an ongoing process that will be completed daily. Reported findings will be discussed through the QA process. See attachment #16 (Staffing Sheet).	

Provider's Signature _____ Title _____ Date _____