STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085042	A. BUILDING _____ B. WING _____	04/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRACKENVILLE CENTER	100 ST. CLAIRE DRIVE HOCKESSIN, DE 19707

(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 and Emergency Preparedness survey was conducted at this facility beginning April 2, 2019 through April 17, 2019 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 101. 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 Survey reposted due to errors in the e POC system. Scope and severity of F 812 reentered. An unannounced annual survey was conducted at this facility from April 2, 2019 through April 17, 2019. The deficiencies contained in this report are based on observation, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 101. The survey sample totaled 56 residents. Abbreviations and definitions used in this report are as follows: ADLS - Activities of Daily Living/includes bathing, eating, dressing, toileting, grooming, mobility, and personal hygiene; Adult Failure to Thrive - a state of decline that is multifactorial and may be caused by chronic	F 000		

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

Electronically Signed | 05/20/2019

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F 000	Continued From page 1 concurrent diseases and functional impairments. Manifestations of this condition include weight loss, decreased appetite, poor nutrition, and inactivity; Biologicals - a therapeutic substance, such as a vaccine or drug, derived from human sources; CNA - Certified Nurse Aide; C-Diff - bacterial overgrowth that releases toxins that attack the lining of the intestines; DON - Director of Nursing; DM - Diabetes Mellitus, a chronic condition that affects the way the body processes blood sugar; FlexPen - a prefilled insulin pen; FSD - Food Service Director; Gait Belt - belt used for safety to transfer and ambulate residents; Humalog - fast acting insulin; Humulin - short acting insulin; ID - Infectious Disease; Insulin - used in the treatment of people with diabetes who produce little or no insulin; Kardex - a medical information system used by nursing staff as a way to communicate important information on their patients; LPN - Licensed Practical Nurse; MD - Medical Doctor; MDS - Minimum Data Set/standardized assessment tool used in Long Term Care facilities; Neurogenic bladder - a person lacks bladder control due to a brain, spinal cord, or nerve condition; NHA - Nursing Home Administrator; Novolog - fast acting insulin; NP - Nurse Practitioner; Phytoplex Z-Guard - a medication used to treat and prevent diaper rash and other minor skin irritations like burns, cuts and scrapes. It works by forming a barrier on the skin to protect it from	F 000		

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F 000	Continued From page 2 irritants/moisture; PPD Diluted Aplisol - a sterile solution used as an aid in the diagnosis of tuberculosis via a skin test; PRN - as needed; PROM - Passive Range Of Motion; Purulence - containing pus; RN - Registered Nurse; Sacral - relating to the sacrum, a large, triangular bone at the base of the spine; Slough - yellow, tan, gray, green or brown dead tissue; Subcutaneous Injection - an injection into the fatty tissue, an area that has a layer of fat between the skin and the muscles; UM - Unit Manager; Urinary Incontinence - loss of bladder control.	F 000		
F 550 SS=E	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	F 550		6/5/19

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F 550	Continued From page 3 practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations and interview, it was determined that the facility failed to promote care for numerous residents (R22,R37,R60,R3,R4,R6,R28,R30,R43,R46,R58, R81,R89 and R35) in a manner and in an environment that maintained or enhanced each resident's dignity and respect. Findings include: 1. An observation on 4/2/19 at 12:35 PM in the West Wing dining room revealed E4 (Dietary Aide) serving lunch to multiple residents, including R22, R37 and R60, while wearing gloves. 2. Observations on 4/5/19 from 9 AM to 9:30 AM in the 100 and 300 hallways revealed facility staff serving assorted juices (orange and apple) in	F 550	(1) A. Resident R35 had a fig leaf privacy foley bag, however staff were instructed to place the fig leaf foley bag in another privacy bag. B. All other residents with a foley bag will be provided with a self contained foley bag that provides privacy and dignity C. Root cause analysis was completed to determine the cause of deficient practice C. Center will only purchase and provide self contained foley bags to maintain the privacy and dignity	

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F 550	Continued From page 4 small white Styrofoam cups to the following residents: R3, R4, R6, R28, R30, R43, R46, R58, R81 and R89. Findings were reviewed with E1 (NHA) and E2 (DON) on 4/10/19 at 4:30 PM. The facility failed to promote care for residents in a manner and in an environment that maintained or enhanced each resident's dignity and respect. 3. Review of R35's clinical record revealed: 7/30/18 - R35 was admitted to the facility with diagnoses including neurogenic bladder. 7/31/18 - A care plan was developed for use of an indwelling foley catheter due to neurogenic bladder, with interventions including, catheter care twice a day and PRN (as needed), keep catheter off floor and provide a privacy bag. 4/2/19 at 3:18 PM - R35 was observed resting in bed with the foley catheter attached to the bed, hanging off the floor, but there was no privacy bag. 4/3/19 at 12:47 PM - R35 was observed eating in the East Wing dining room along with R35's spouse and other residents. The indwelling foley catheter bag was noted to have no privacy bag. 4/4/19 at 11:39 AM - R35 was observed attending worship service at the chapel with his/her spouse and other residents. 4/4/19 at 11:58 AM - R35 was seen coming out from the worship service, on his/her mobile scooter in the hallway, and the indwelling foley catheter lacked a privacy bag.	F 550	C. As a result of the root cause analysis, Nurse Practice Educator or designee will reinservice all nursing staff on the appropriate foley bag to use to maintain the privacy and dignity D. DON or designee will complete audits on all residents with a foley bag daily x s 7 days to ensure 100% compliance; then weekly x s 4 weeks to ensure 100% compliance than monthly x s 3 months to ensure 100% compliance D. QAPI committee will review audits results monthly x's 3 months than will be included in the Quarterly QAPI meetings to identify trends (2) A. R3,R4,R6,R22,R28,R30,R37,R43,R46,R58,R60,R81 and R89 had no negative outcome as a result of the deficient practice B. All residents have the potential to be affected by this deficient practice C. Root cause analysis was completed to determine reason for deficient practice C. As a result of the root cause analysis, Food Service Director or designee will reinservice all dietary staff on the appropriate way to serve meals while maintaining infection control.	

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F 550	Continued From page 5 4/8/19 at 3:30 PM - During an interview, E2 (DON) stated that the facility uses a privacy bag to cover the foley catheter bag. 4/10/19 in PM - R35 was observed eating lunch at the East Wing dining room with his/her spouse and other residents. The indwelling foley catheter bag was noted to have no privacy bag. 4/10/19 - Instructions for care on the CNA (Certified Nurse Aide) Kardex included to keep the catheter off of the floor and provide a privacy bag. 4/17/19 at 9:10 AM - R35 was seen resting in bed with no privacy bag noted over the foley catheter bag. 4/17/19 at 9:24 AM - During an interview on catheter care and the use of privacy bag, E23 (LPN) stated that residents with indwelling urinary catheters should have a privacy bag to cover the urine and promote residents' dignity. The facility failed to promote care for R35 in a manner and in an environment that maintained or enhanced R35's dignity and respect. Findings were reviewed with E1 (NHA) and E2 at the Exit Conference on 4/17/19 beginning at 2:45 PM.	F 550	C. Acrylic cups will be ordered to insure no further use of styrofoam unless under extreme circumstances D. Food Service Director or Designee will complete Audits daily x s 7 days to ensure 100% compliance; then weekly x s 4 weeks to ensure 100% compliance than monthly x s 3 months to ensure 100% compliance D. QAPI committee will review audits results monthly x's 3 months than will be included in the Quarterly QAPI meetings to identify trends	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced	F 641		6/5/19

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F 641	Continued From page 6 by: Based on clinical record review and interview, it was determined that for 2 (R37 and R88) out of 56 sampled residents, the facility failed to accurately reflect the residents' status on comprehensive assessments. Findings include: 1. Review of R37's clinical record revealed: 4/18/17 - R37 was admitted to the facility. 4/18/17 at 11:32 AM - The admission nursing assessment stated that R37's lower extremities (hip, knee, ankle, foot) had impairment on both sides with respect to functional limitation in range of motion; R37 had contractures of the lower extremities. 4/25/17 - The admission MDS assessment incorrectly coded that R37 had no impairment of the lower extremities with respect to functional limitation in range of motion. 4/10/19 at 11:45 AM - Findings were confirmed with E2 (DON), E3 (ADON) and E6 (RNAC). 2. Review of R88's clinical record revealed the following: 2/21/19 - R88 was readmitted to the facility following a hospitalization. The readmission skin assessment documented that R88 had an open pressure area to the right buttock measuring 4.2 cm x 2.0 cm. 2/28/19- A significant change MDS assessment was completed and did not indicate that R88 had a pressure ulcer. 4/17/19 at 9:36 AM - During an interview with E22 (Clinical Reimbursement), it was confirmed that R88's right buttock pressure ulcer was not coded on his/her 2/28/19 significant change MDS	F 641	(1) A. R88 was discharged on 4/5/2019 B. All other residents with open areas will have their MDS assessments reviewed to insure open areas are identified correctly on the MDS assessment. Those residents with open areas are not identified will have the MDS assessment corrected to identify the open area. C. Root cause analysis will be completed to determine the cause of deficient practice C. Based on the results of the root cause analysis Nurse Practice Educator or designee will reinservice Unit Managers, MDS Coordinator and RNAC, on identifying open areas and documenting them correctly on the MDS assessment D. DON or designee will conduct audits of all residents with open areas weekly x s 4 weeks to insure residents with open areas have the correct assessment completed. Once 100% compliant than audits will be conducted monthly x s 3 months. D. QAPI committee will review audits results monthly x's 3 months, than include in Quarterly QAPI meetings to identify trends (2) A. R37 will have her MDS assessment	

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F 641	Continued From page 7 assessment. The facility failed to accurately code R88 as having a pressure ulcer on his/her 2/28/19 significant change MDS assessment. 4/17/19 at 2:45 PM- Findings were reviewed during the exit conference with E1 (NHA) and E2 (DON).	F 641	corrected to reflect her functional limitations in her lower extremities B. All other residents with functional limitations will have their MDS assessments reviewed to determine if the functional limitations are correctly reflected in their MDS assessment. Those residents identified with extremity limitations not reflected correctly will have their MDS assessments corrected C. Root cause analysis will be completed to determine the cause of deficient practice C. Based on the results of the root cause analysis the Nurse Practice Educator or designee will reinservice all Unit Managers, MDS Coordinator and RNAC on identifying functional limitations in extremities and documenting them correctly on the MDS assessment D. DON or designee will conduct audits of all residents with functional limitations weekly x' s 4 weeks to insure residents with functional limitations have the correct MDS assessment completed. Once 100% compliant than audits will be conducted monthly x s 3 months until 100% compliant D. QAPI committee will review audits results monthly x's 3 months than include in quarterly QAPI meetings to identify trends	
F 642	Coordination/Certification of Assessment	F 642		6/5/19

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F 642 SS=D	Continued From page 8 CFR(s): 483.20(h)-(j) §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1)Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to accurately record and track a Discharge MDS (Minimum Data Set) Assessment for 1 (R88) out of 56 sampled residents who had unplanned transfers to the hospital. R88 had an unplanned transfer to the hospital on 12/11/18. R88's MDS was coded as DNRA (Discharge Return Not Anticipated)	F 642	A. R88 was discharged to home 12/18/2018 by CMS guidelines the discharge return not anticipated MDS and MDS readmission cannot be corrected due to discharge prior to survey B. All residents that had a hospital stay in since 2/1/2019 will have their records	

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F 642	Continued From page 9 however, R88 returned to the facility on 12/22/2018. Findings include: Review of R88's clinical record revealed the following: 11/16/18 - R88 was admitted to the facility. 12/11/18 - R88 was transferred to the hospital for rectal bleeding. The MDS tracking record and assessment revealed a Medicare - 5 Day/Start of Therapy/DRNA (Discharge Return Not Anticipated. 12/22/18 - R88's MDS was recorded for Entry. 12/29/2018 - A new admission 15 day assessment was created. 4/10/19 at 12:50 PM - During an interview, E22 (Clinical Reimbursement) stated that she did not know where R88 went when he left the facility on 12/11/18. When asked how to determine MDS tracking when the facility sends a resident to the hospital, E22 answered, "I don't know, I can't remember exactly what happened at that time for R88 so I recorded him as DRNA. When R88 returned, I had to follow the MDS flow of doing an admission assessment." E22 began to check R88's notes in the EHR (Electronic Health Record) and confirmed to the surveyor that the DRNA on 12/11/18 was a mistake. The facility failed to accurately record and track a Discharge MDS (Minimum Data Set) Assessment when R88 had an unplanned transfer to the hospital on 12/11/18. R88's MDS was mistakenly recorded and tracked as DNRA however, R88 returned to the facility on 12/22/18 and was	F 642	reviewed to insure the proper MDS assessment was completed upon discharge to the hospital and with the readmission from the hospital. C. Root Cause analysis will be completed to establish a reason for the deficient practice C. Based on the results of the root cause analysis the Nurse practice educator or designee will re-inservice the MDS Coordinator/RNAC staff on properly coding the MDS to accurately reflect return anticipated vs. return not anticipated when a resident is transferred and admitted to the hospital D. DON or designee will conduct audits monthly x's 3 months of all residents transferred and admitted to the hospital to insure 100% compliance that the proper MDS assessment was completed upon discharge and return from the hospital D. Results of audits will be reviewed monthly x's 3 months than included for review during quarterly QAPI meeting to identify trends	

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F 642	Continued From page 10 incorrectly recorded as an admission entry. Findings were reviewed with E1 (NHA) and E2 (DON) during the Exit Conference on 4/17/19 beginning at 2:45 PM.	F 642		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires	F 645		6/5/19

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F 645	Continued From page 11 specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to conduct a	F 645	A. Center will contact the state for the expired 30-day exemption Passar for R95	

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F 645	Continued From page 12 pre-admission screening for one (R95) out of 3 sampled residents after 30 days. Findings include: Review of R95's clinical record revealed the following: 2/27/19 - R95 was admitted to the facility with diagnoses that included Major Depressive Disorder. 2/27/19 - A physician ordered Sertraline (Zoloft) HCL (hydrochloride) 25 mg 1 tablet by mouth daily for depression. 2/27/19 - The hospital completed an Exemption from PASRR Assessment form for R95 that stated his /her admission was not expected to exceed 30 days. 3/14/19 - An Interdisciplinary Team Meeting note stated that R95's discharge date would be 4/19/19. 4/17/19 at 10:15 AM - During an interview, E9 (Director of Social Services) stated that a PASRR screen was not done for R95 because of his/her short stay and anticipated discharge date of 4/19/19. The facility failed to conduct a PASRR Preadmission Screening and Resident Review for R95 when his/her stay in the nursing facility exceeded 30 days. Findings were reviewed with E1 (NHA) and E2 (DON) during the Exit Conference on 4/17/19 beginning at 2:45 PM.	F 645	B. All other residents with a 30-day exemption will have the record reviewed to determine if the 30 day exemption has expired. If a resident has an expired 30 day exemption the state will be contacted C. Root cause analysis will be completed to determine the cause of the deficient practice C. Based on the results of the root cause analysis the Nurse practice educator or designee will reinservice the Social Service employees on procedure for the handling of PASSAR documentation D. Center Executive Director or designee will conduct audits of all new admissions with 30-day exemptions to determine if the exemption has expired and if the state was contacted. Audits will be conducted monthly x s 3 months until 100% compliant D. Results of audits will be reviewed monthly x's 3 months than included for review during quarterly QAPI meetings to identify trends	

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F 656	Continued From page 13	F 656		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate	F 656		6/5/19

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F 656	Continued From page 14 entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on clinical record reviews and interviews, it was determined that the facility failed to develop and implement comprehensive person-centered care plans for two (R46 and R90) out of 56 residents sampled. For R90, the facility failed to develop a care plan for being at risk of bleeding due to receiving the anticoagulant (blood thinning medication), Apixaban. For R46, the facility failed to care plan for every 2 hour checks and changes for incontinence after R46 declined to go to the bathroom or use any toileting devices such as a bedside commode. Findings include: 1. R90 was admitted to the facility on 12/7/18. Review of the 12/7/18 admission physician's orders revealed R90 was receiving the blood thinning medication Apixaban, which had the potential to cause bleeding. Although the facility developed a comprehensive care plan, they failed to include R90's risk for bleeding due to receiving Apixaban. During an interview on 4/16/19 at approximately 9:00 AM, E2 (DON) confirmed that a care plan for the use of Apixaban should have been implemented. 2. Review of R46's clinical record revealed the following:	F 656	(1) A. R90 was discharged from the center on 4/7/2019 B. All other residents that receive anticoagulant therapy will have the care plan reviewed to determine if potential for bleeding is included in the anticoagulant therapy care plan. Those that do not have potential for bleeding reflected will have their anticoagulant therapy care plan corrected to reflect potential for bleeding C. Root cause analysis was completed to determine the cause of deficient practice C. Based on the results of the root cause analysis the Nurse Practice Educator or designee will reinservice all nurses on including potential for bleeding in the resident care plan for anticoagulant therapy. D. Center Nurse Executive or designee will audits a sample size of 10% of those on anticoagulant therapy to determine if the anticoagulant therapy care plan reflects potential for bleeding. Audits will be conducted monthly x s 3 months until 100% compliant	

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F 656	Continued From page 15 R46 was admitted to facility on 1/30/19. The admission MDS, completed 2/6/19, indicated that R46's ADL status was total dependence on staff for care. R46 had moderate cognitive impairment (decisions poor; cues/supervision required). The incontinence assessment titled "Urinary Incontinence Nursing Interventions" on 2/5/19, completed by E10 (UM) indicated "Check and change at least q (every) 2 hours" after R46 declined to proceed with being taken to the bathroom or using any toileting devices. R46 had an incontinence care plan, last revised on 3/14/19, for toileting prn (as needed). The care plan, reviewed on 4/15/19, did not include the recommendation for at least every 2 hour checks and changes as per the 2/5/19 incontinence assessment. Findings were reviewed and confirmed with E2 (DON) on 4/15/19 at approximately 11:30 AM. Findings were reviewed with E1 (NHA) and E2 during the Exit Conference on 4/17/19 beginning at 2:45 PM.	F 656	D. QAPI committee will review audits results monthly x's 3 months than include for review during the quarterly QAPI meetings, to identify trends (2) A. The care plan of R46 has been updated to include the recommendation for the revised check and change protocol B. All other residents whose incontinent assessment indicates check and change will have their care plans reviewed and updated per the revised check and change protocol. C. Root cause analysis was completed to determine the cause of deficient practice C. Based on the root cause analysis, the center has modified the Check and Change policy from every 2 hours to upon awakening, before meals, at bedtime and as needed. C. Based on the results of the root cause analysis the Nurse practice Educator or designee will reinservice all nursing staff on the revised check and change protocol D. Center Nurse Executive or designee will conduct audits weekly x s 4 weeks to insure residents have check and change in the care plan of residents whose incontinent assessment indicates check and change. Once 100% compliant than audits will be conducted monthly x s 3 months until 100% compliant	

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F 656	Continued From page 16	F 656	D. QAPI committee will review audits monthly x's 3 months than include for review during the quarterly QAPI meetings to identify trends	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was	F 657	(1)	6/5/19

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F 657	Continued From page 17 determined that for 3 (R37, R40 and R46) out of 56 residents sampled for investigations, the facility failed to ensure that care plans were developed by the IDT (Interdisciplinary Team) which included the attending physician, and a nurse aide with responsibility, a staff member of the Nutrition/Dietary Department. The facility also lacked evidence that other professionals in disciplines as determined by the resident's needs, attended care plan meetings. For R37, a hospice representative did not attend the 11/12/18 and the 2/11/19 care plan meetings. Findings include: 1. The following was reviewed in R40's clinical record: 1/29/19 - R40 was admitted to the facility from the hospital. 2/5/19 - An Admission MDS was completed. 2/19/19 - A progress note documented that an IDT care plan meeting was held. There was lack of evidence that R40's attending physician, CNA responsible for R40 and/or the staff of the Nutrition/Dietary Department was invited and/or attended. 4/15/19 at approximately 1:10 PM - An interview with E9 (DSS) was conducted. E9 verbalized that the attending physician, CNA assigned to the resident and Nutrition Dietary staff did not routinely attend the IDT meetings. E9 provided a copy of a written policy and procedure, which stated that the IDT members included the attending physician, the RN responsible for the patient, CNA with responsibility of the patient, Social Service, Food and Nutrition.	F 657	A. R40 had no negative outcome as a result of the deficient practice B. All other residents have the potential to be effected by this deficient practice C. Root cause analysis was completed to determine the reason for the deficient practice C. Based on the results of the root cause analysis the Nurse Practice Educator or designee will reinservice all care plan team members and nursing units on the policy and procedure for Person Centered Care Plans and care plan meetings D. Center Nurse Executive or designee will conduct audits weekly x s 4 weeks to insure resident Person Center Care Plans reflect attendance or through alternative methods, provides input by the appropriate members of the care plan team as included in the policy and procedure. Once 100% compliant than audits will be conducted monthly x s 3 months until 100% compliant D. QAPI committee will review audits monthly x's 3 months than include for review during the quarterly QAPI meetings to identify trends (2) A. R37 had no negative outcome as a result of the deficient practice	

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F 657	Continued From page 18 2. Review of R37's clinical record revealed: 4/24/17 - R37 was care planned by hospice for integration of the nursing home and the hospice plan of care with an intervention to determine facility care plan meeting dates; arrange to attend, collaborate, and integrate the plan of care. 10/9/18 - A hospice recertification of terminal illness stated that R37 was receiving hospice services from 10/6/18 through 12/4/18. 11/12/18 - Review of the sign-in sheet for R37's care plan meeting lacked evidence that a hospice representative attended the care plan meeting. 1/29/19 - A hospice recertification of terminal illness stated that R37 was receiving hospice services from 2/3/19 through 4/3/19. 2/11/19 - Review of the sign-in sheet for R37's care plan meeting lacked evidence that a hospice representative attended the care plan meeting. 4/10/19 at 4:30 PM - Findings were reviewed with E1 (NHA) and E2 (DON). The facility failed to include a hospice representative in R37's care plan meetings on 11/12/18 and 2/11/19.	F 657	B. All hospice residents have the potential to be affected by this deficient practice C. Root cause analysis was completed to determine the cause of the deficient practice C. Center Nurse Executive or designee has communicated with current hospice providers about their required attendance in Hospice patient care plans and care plan meetings C. Based on root cause analysis, NHA or designee will reinservice the Social Service Director concerning communicating the Care Plan schedule for Hospice patients to the appropriate people in the Hospice organization D. Center Nurse Executive or designee will conduct audits weekly x s 4 weeks to insure resident Person Center Care Plans reflect attendance or through alternative methods, provides input by the appropriate members of the care plan team as included in the policy and procedure. Once 100% compliant than audits will be conducted monthly x s 3 months until 100% compliant D. QAPI committee will review audits monthly x's 3 months than include for review during the quarterly QAPI meetings to identify trends	
F 684 SS=D	Quality of Care CFR(s): 483.25	F 684		6/5/19

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F 684	Continued From page 19 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, interview, and review of other facility documentation as indicated, it was determined that the facility failed to provide care and services in accordance with professional standards of practice for one (R53) out of 56 sampled residents. The facility failed to ensure the resident's bowel movement (BM) activity was monitored, which resulted in failure to follow the facility's bowel regimen. Findings include: The facility' Standing Order for constipation included: - If no BM in 3 days; give Milk of Magnesia (MOM) 30 mLs x 1 by mouth. - If no BM within next shift, give Dulcolax suppository per rectum times one. - If no BM within two hours, give Fleets enema. - If no results from Fleet enema, call physician/advanced practice provider for further orders. The following was reviewed in R53's clinical record: From night shift on 2/8/19 to night shift on 2/12/19 - No BM activity for a total of 14 shifts.	F 684	A. R53 had no negative outcome as a result of the center not following the Bowel Protocol B. All other residents have the potential to be affected by the deficient practice C. Root Cause analysis was completed to reflect the cause of the deficient practice C. Based on the results of the root cause analysis the Nurse Practice Educator or designee will reinservice all nurses on the center Bowel protocol D. Center Nurse Executive or designee will conduct audits daily x s 7 days to insure the bowel protocol is being followed as per policy. Once 100% compliant than audits will be conducted weekly x s 4 weeks until 100% compliant than monthly x s 3 months until 100% compliant. Sample size of the audits will be 4 residents from each unit for a total of 8 resaidents identified for the bowel protocol D. QAPI committee will review audits	

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F 684	Continued From page 20 2/14/19 - A Physician's Order was written for 1 cup of prune juice daily. From night shift on 2/23/19 to evening shift on 2/27/19 - No BM activity for a total of 14 shifts. From day shift on 3/1/19 to night shift on 3/5/19 - No BM activity for a total of 13 shifts. 4/15/19 at approximately 1:00 PM - An interview with E10 (UM, RN) confirmed that the facility failed to implement the bowel protocol after no BM for 3 days during the above periods of time. Findings were reviewed with E1 (NHA) and E2 (DON) during the Exit Conference on 4/17/19 beginning at 2:45 PM.	F 684	monthly x's 3 months than include for review during quarterly QAPI meetings to identify trends	
F 688 SS=E	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable.	F 688		6/5/19

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F 688	Continued From page 21 This REQUIREMENT is not met as evidenced by: Based on clinical record review and interview, it was determined that for 1 (R37) out of 6 sampled residents, the facility failed to ensure that a resident with limited range of motion received appropriate treatment and services to maintain and/or prevent further decrease in range of motion. The facility lacked evidence that passive range of motion (PROM) was provided to R37 from 7/21/17 through 4/8/19, approximately 21 months. Findings include: Review of R37's clinical record revealed: 7/10/17 - A quarterly MDS assessment stated that R37 had impairment with functional limitation in range of motion of her lower extremities (includes hips to toes). 7/20/17 - R37 was care planned for exhibiting or at risk for alterations in functional mobility related to contracture deformity: preventive and treatment with an intervention to perform PROM to bilateral (both sides) upper extremities (includes shoulders to fingers) and bilateral lower extremities twice a day for 15 minutes. 7/20/17 - Review of the CNA's Kardex (also referred to as the CNA care plan) revealed that the intervention for PROM was listed. 7/21/17 through 4/8/19 - Review of the CNA documentation reports revealed a lack of evidence that R37 was receiving PROM twice a day for 15 minutes. 4/10/19 at 11:45 AM - Findings were reviewed with E2 (DON), E3 (ADON) and E6 (RNAC). The	F 688	A. R37 had no negative outcome due to lack of documented evidence of PROM provided between July 2017-April 2019 B. All other residents requiring PROM have the potential to be affected by the lack of evidence of PROM provided C. Root cause analysis was completed to determine the cause of the deficient practice C. Based on the results of the root cause analysis, the Nurse Practice Educator or designee will reinservice all nursing staff on documenting and the proper way to perform PROM D. Center Nurse Executive or designee will conduct audits daily x s 7 days to insure the residents that require PROM have documented evidence that PROM is occurring. Once 100% compliant than audits will be conducted weekly x s 4 weeks than monthly x s 3 months until 100% compliant D. QAPI committee will review audits monthly x's 3 months than include for review during the quarterly QAPI meetings to identify trends	

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F 688	Continued From page 22 facility lacked evidence that PROM was provided to R37 from 7/21/17 through 4/8/19, approximately 21 months.	F 688		
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 review, interviews and review of facility documents, it was determined that the facility failed to ensure that one (R89) out of three (3) residents sampled for investigation were transferred according to the care plan. Although it is unclear how R89 sustained a significant skin tear, it occurred during a stand/pivot transfer in which a gait belt was to be used, but was not. The facility failed to follow R89's care plan for transfers. Findings include: Review of R89's clinical record revealed the following: R89 was admitted to the facility in 2012. 7/3/17 - A care plan for requires assistance for ADLs, revised on 4/19/18, stated that R89 required one (1) person assistance with transfers using a gait belt. 12/21/18 - An annual MDS assessment stated	F 689	A. R89 had her transfer status re-evaluated and the care plan was updated to reflect any change as a result of that evaluation. B. All residents will have their transfer status re-evaluated and their care plans will be updated to reflect any change in their transfer status as a result of the evaluation. C. Root cause analysis has been completed to determine the cause of the deficient practice C. The Nurse practice educator or designee will reinservice all nursing staff on the policy and procedure to determine and document resident transfer status D. Center Nurse Executive or designee will conduct audits 10% of residentweekly	6/5/19

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F 689	Continued From page 23 R89 required extensive assist of one (1) staff for transfers to and from bed to a wheelchair. 1/1/19 - The facility completed a Lift Transfer Reposition assessment that stated the resident was able to weight-bear = (equal) or > (greater than) 50% on one or both legs, and was able to consistently perform a stand-pivot transfer with limited assist: GAIT/TRANSFER BELT required. 1/8/19 - Review of the facility's Event Summary Report revealed that R89 sustained a significant skin tear to the left lower leg when transferred by E11 (CNA) from the wheelchair to the bed. The report stated that E11 noticed bleeding after the transfer, but it was not clear where or how the injury occurred. R89 required an emergency room visit for treatment, which included suturing of the skin tear. The facility's Summary of Investigation: Root cause/conclusion: stated, " Uncertain of what he/she actually got injured on. There was only one rough edge on the wheelchair's right arm rest, and it doesn't make sense with the nature of the transfer and the location of the wound. Corrective Actions: Review with the CNA proper technique in transferring residents." 1/8/19 6:15 PM - A written statement completed by E11 (CNA) stated that she transferred R89 by completing a stand/pivot transfer from the wheelchair to the bed. E11 wrote that once R89 was in bed she (CNA) noticed blood on her hands. E11 thought it was from an older skin tear, but upon examining the leg saw that it was a new skin tear and immediately called the nurse. 1/10/19 - Review of documents revealed that E11 (CNA) was inserviced by E12 (Staff Educator) on "Safe Resident Handling regarding stand pivot	F 689	x's 4 weeks to determine if residents are being transferred as per the care plan. Once 100% compliant than audits will be conducted monthly x s 3 months until 100% D. QAPI committee will review audits monthly x's 3 months than include for review as part of the quarterly QAPI meeting to identify trends	

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F 689	Continued From page 24 transfer and equipment check." It was noted that E11 was able to demonstrate proper technique and body mechanics in transferring R89 from the wheelchair to the bed and also from the bed to the wheelchair. 1/14/19 through 1/16/19 - Documentation revealed that E12 (Staff Educator) inserviced all of the nursing staff on proper transfers. 1/15/19 - Documentation revealed that a facility wide audit was completed on all wheelchairs that were currently in use by residents. A re-check audit was completed on 2/8/19. 4/11/19 4:10 PM - An interview was conducted with E11 (CNA). E11 stated that back then, R89 was a one person assist stand/pivot for transfers. E11 stated that R89 was able to do more for himself/herself back then. E11 stated that R89 was able to self propel his/her wheelchair, was able to hold the bathroom grab bar to stand pivot to the toilet and back. E11 stated that evening she pushed R89 into the bathroom, who was then able to use the grab bar to stand/pivot to the toilet. R89 was able to transfer back to the wheelchair and was washed up at the sink and brushed his/her teeth. E11 stated that she wheeled R89 to his/her bed, completed a stand/pivot transfer and positioned a pillow under R89's legs to raise the heels. E11 stated that when she removed her hands from under the pillow, she noticed blood on her hands. E11 stated that the blood was only by the bed, there was none in the bathroom. When asked how she (CNA) got R89 up to stand, did the resident hold onto her shoulders or waist? E11 stated that she grabbed the back of R89's pants to hold R89 when she transferred the resident.	F 689		

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F 689	Continued From page 25 4/16/19 1:42 PM - During a second interview with E11 (CNA), it was confirmed that she had not used a gait belt during R89's transfer on 1/8/19 when the skin tear was sustained. E11 was not able to recall the position of the leg rests or if there were leg rests present at that time. 4/17/19 8:35 AM - During an interview with E12 (Staff Educator), she confirmed that E11 (CNA) and all nursing staff have been inserviced on proper transfers. E12 stated that it was not clear how the injury occurred, that she herself had inspected the bed and wheelchair and was unable to find any issues. E12 also stated that R89 did not have leg rests on his/her wheelchair and E11 was able to complete a return demonstration without any problem. Although it is unclear how R89 sustained the significant skin tear to the left lower leg, the facility failed to follow the care plan which stated that a gait belt was to be used for transfers. Findings were reviewed with E1 (NHA) and E2 (DON) on 4/17/19 at approximately 2:45 PM during the exit conference.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.	F 690		6/5/19

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F 690	Continued From page 26 §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, interview, and review of resident clinical records, it was determined that the facility failed to ensure that appropriate treatment and services were provided for urinary incontinence care for 1 (R46) out 1 residents. Findings include: R46 was admitted to facility on 1/30/19. The admission MDS, completed 2/6/19, indicated that R46's ADL status was total dependence on	F 690	A. R46 had no negative outcome as a result of the deficient practice. B. All other residents with orders for check and change have the potential to be affected by this deficient practice. C. Root cause analysis was completed to determine the cause of the deficient practice	

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F 690	Continued From page 27 staff for care. R46 had moderate cognitive impairment (decisions poor; cues/supervision required). The incontinence assessment titled "Urinary Incontinence Nursing Interventions" on 2/5/19, completed by E10 (UM) indicated "Check and change at least q (every) 2 hours" after R46 declined to proceed with being taken to the bathroom or using any toileting devices, such as a bedside toilet. It was observed on 4/3/19 from 10:00 AM to 2:30 PM and 4/15/19 from 7:50 AM to 11:00 AM that staff did not enter R46's room. The care plan reviewed on 4/15/19 failed to include the recommendation for 2 hours check and change under the resident's continence care. The facility failed to follow E10's recommendation for 2 hour check and change as per observations on 4/3/19 and 4/15/19. Findings were reviewed and confirmed with E2 (DON) on 4/15/19 at approximately 10:30 AM. Findings were reviewed with E1 (NHA) and E2 (DON) during the Exit Conference on 4/17/19 beginning at 2:45 PM.	F 690	C. Based on the root cause analysis, the center has revised the check and change protocol to upon awakening, before meals, at bedtime and as needed. C. Based on the root cause analysis, the Nurse Practice Educator or designee will inservice all nursing staff on the revised protocol for check and change D. Center Nurse Executive or designee will conduct audits of 10% of those identified as check and change weekly x s 4 weeks until 100% compliant than monthly x s 3 months until 100% compliant D. QAPI committee will review audits monthly x's 3 months than will be included for review during the quarterly QAPI meeting to identify trends	
F 725 SS=D	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest	F 725		6/5/19

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F 725	Continued From page 28 practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §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 observation and interview, it was determined that for 1 (R37) out of 56 sampled residents, the facility failed to have sufficient nursing staff to provide nursing and related services. Findings include: 4/5/19 at 9 AM - An observation in the 300 hallway revealed that R37's breakfast was delivered to his/her room and placed on the overbed table. At 9:20 AM, after delivering meals and pouring fluids for other residents in the 300 hallway, E7 (CNA) entered R37's room and elevated the head of bed and proceeded to feed the resident. R37, a totally dependent resident, waited 20 minutes to be fed while his/her	F 725	A. R37 had no negative outcome as a result of this deficient practice B. All other residents that require assistance and eat in their rooms have the potential to be effected by this deficient practice C. Root cause analysis was completed to determine the reason for the deficient practice C. Based on the root cause analysis the procedure for delivery of meals to residents that eat in their rooms and	

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F 725	Continued From page 29 breakfast sat on the overbed table. 4/10/19 at 4:30 PM - Finding was reviewed with E1 (NHA) and E2 (DON). The facility failed to have sufficient nursing staff to provide nursing and related services	F 725	require assistance eating has been revised to limit any delay between residents receiving their food and provided assistance eating their food. C. The Nurse Practice Educator or designee will inservice nursing and dietary staff on the change in protocol for delivery of meals to residents that eat in their rooms and require assistance with eating D. Center Nurse Executive or designee will conduct an audit of 4 residents weekly x's 4 weeks to determine if there was a delay in delivery of meals and the resident receiving assistance until 100% compliant than monthly x s 3 months until 100% compliant D. QAPI committee will review audits monthly x's 3 months than include for review during quarterly QAPI meetings to identify trends	
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,	F 755		6/5/19

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F 755	Continued From page 30 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 by: Based on observation and interview, it was determined that the facility failed to 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. Review of two (2) out of three (3) medication carts revealed the presence of expired medications and/or biologicals. Findings include: 1. On 4/15/19 at 11:25 AM, the 500 wing medication cart was observed with E16 (RN). Observation revealed a blister pack of Mirtazapine, labeled for R63, that had expired on 3/31/19. E16 confirmed the medication had expired and should have been removed from the medication cart.	F 755	A/B. All residents have the potential to be affected by this deficient practice C. A root cause analysis has been completed to determine the cause of the deficient practice C. As a result of the root cause analysis, the Nurse Practice Educator or designee will reinservice all licensed nurses on the handling of expired medications. D. Center Nurse Executive or designee will conduct audits on all carts weekly x s 4 weeks to insure that expired medications are disposed of timely and properly. Once 100% compliant than audits will be conducted monthly x s 3	

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F 755	Continued From page 31 2. On 4/15/19 at 11:55 AM, the 200 wing medication cart was observed with E17 (LPN). Observation revealed the following: - A vial of Humalog insulin was noted as opened on 3/6/19. The vial is considered expired 28 days after opening; - A vial of Humulin insulin was noted as opened on 3/14/19 and should have been discarded 28 days after opening; - A Novolog insulin FlexPen was labeled as opened on 2/28/19 and expired on 3/26/19; - A Lantus insulin vial was labeled as opened 2/28/19 and expired on 3/26/19. Interview with E10 (UM) on 4/15/19 at 12:15 PM, confirmed the above listed insulins had expired and should not be on the medication cart. Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 4/17/19 at approximately 2:45 PM.	F 755	months until 100% compliant D. QAPI committee will review audits monthly x's 3 months than include for review during quarterly QAPI meeting to identify trends	
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 Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized	F 761		6/5/19

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F 761	Continued From page 32 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 the facility failed to store a biological (PPD) under proper temperature control for one (1) of three (3) medication carts reviewed. The facility failed to refrigerate an opened vial of PPD Diluted Aplisol, instead leaving it on the 200 wing medication cart. Findings include: Observation of the 200 wing medication cart revealed an opened vial of PPD. The vial was labeled that refrigeration was required. Interview with E10 (UM) on 4/15/19 at 12:15 PM confirmed that the PPD vial should not be stored on the medication cart. Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 4/17/19 at approximately 2:45 PM.	F 761	A/B. All residents have the potential to be affected by this deficient practice C. The vial identified as left out was disposed of and all med carts were checked to identify other TB vials potentially left out of refrigerator. No other vials were found to be left out of refrigerator. C. A root cause analysis has been completed to determine the cause of the deficient practice C. As a result of the root cause analysis, the Nurse Practice Educator or designee will reinservice all licensed nurses on the storage of TB skin solution. D. Center Nurse Executive or designee will conduct audits of med carts and med rooms weekly x s 4 weeks to insure that TB skin solution is stored correctly. Once 100% compliant than audits will be conducted monthly x s 3 months until 100% compliant.	

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F 761	Continued From page 33	F 761	D. QAPI committee will review audits monthly x's 3 months than included for review results to identify trends	
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to provide food that was palatable, attractive and at an appetizing temperature for the residents. Findings include: Test trays conducted during meals on 4/10/19 revealed the following: 1. Breakfast at a. 8:50 AM on the 500 wing - Biscuit: 111 degrees F - tasted cool, dry, not palatable; Scrambled eggs: 157 degrees F - tasted lukewarm, not palatable; Sausage: 120 degrees F - lukewarm, not palatable. b. 9:30 AM on the 300 wing - Pureed eggs: 175 degrees F - bland to taste;	F 804	A/B. All residents have the potential to be affected by this deficient practice C. Root cause analysis identified that there was too much food sent out on the cart serving the floor to maintain temperatures. The food cart will be replenished with food from steam table in kitchen when going from east unit to west unit. C. Food Service Director or designee will reinservice dietary staff on change in process for serving food to the residents in their rooms. D. Food Service Director or designee will complete temperature audits one meal per day daily, that will include all 3 meals, for 14 days to determine temperatures are	6/5/19

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F 804	Continued From page 34 Pureed sausage: 149 degrees F - runny, grainy. 2. Lunch at a. 12:14 PM on the 600 wing - Vegetable salad: 57.7 degrees F - no dressing, not tasty. b. 1:00 PM on the 300 wing - Shrimp salad: 62.8 degrees F - warm for a cold dish, not palatable; Potato salad: 74 degrees F - warm for a cold dish, not palatable. 3. On 4/9/19 at 1:40 PM, R42 stated breakfast was usually cold. 4. In interviews conducted on 4/10/19 at 10:20 AM and 4/17/19 at 9:15 AM, R3 stated that hot foods were not always hot, and food at times tasted "terrible." 5. On 4/15/19 at 5:50 PM, R43 stated hot foods were not always hot and could be better, and on 4/17/19 at 9:05 AM, R11 stated this day's breakfast items of toast and eggs were not hot enough. These findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 4/17/19 at approximately 2:45 PM.	F 804	at proper levels while food is being served. Once daily audits achieve 90% or greater compliance, temperature audits will be completed weekly x s 4 weeks if 100% compliance is maintained than audits will be completed monthly x s 3 months to maintain 100% compliance D. Food Service Director or designee will conduct audits one meal per day for 7 days of pureed food for palatability. If the daily audit is 100% compliant than the audits will be conducted weekly x's 4 weeks. Once 100% compliant than monthly x's 3 months D. QAPI committee will review audits monthly x's 3 months than include for review during quarterly QAPI meetings to identify trends	
F 808 SS=D	Therapeutic Diet Prescribed by Physician CFR(s): 483.60(e)(1)(2) §483.60(e) Therapeutic Diets §483.60(e)(1) Therapeutic diets must be prescribed by the attending physician.	F 808		6/5/19

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F 808	Continued From page 35 §483.60(e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law. This REQUIREMENT is not met as evidenced by: Based on observations, record review and interviews, it was determined that the facility failed to provide the therapeutic diet that was prescribed by the physician for one (R70) out of four (4) residents sampled for investigation. The facility failed to provide large portion (Protein) entrees for several meals. Findings include: Review of R70's clinical record revealed the following: 9/19/18 - R70 was originally admitted to the facility. 9/20/18 - A care plan for at nutritional risk due to recent significant weight loss was created. 2/18/19 through 2/24/19 - R70 was hospitalized and returned to the facility on 2/24/19 with a diagnosis of Adult Failure to Thrive. 2/26/19 - The readmission Nutritional Assessment stated, "...suggest reordering large portion of entree at meals." 3/7/19 - A physician's order stated R70 was to receive Large Portion Entrees at meals for failure to thrive. 3/21/19 - The care plan for at nutritional risk was revised to include the intervention, "...Large Portion Entree (High Protein) as ordered."	F 808	A. R70 had no negative outcome as a result of the resident not receiving double portions of protein as ordered B. All residents ordered large portions of protein have the potential to be affected by this deficient practice C. Root cause analysis has been completed to determine the cause of the deficient practice C. As a result of the root cause analysis, Food Service Director or designee will reinservice all dietary staff on identifying residents ordered large portion of protein when looking at the meal tickets for food service D. Food Service Director or designee will audit 1 resident daily audits x s 2 weeks to determine that residents ordered large portion of protein receive their meals as ordered. Once 100% compliant, audits will be completed weekly x s 4 weeks, than once 100% compliant the audits will completed monthly x s 3 months until 100% compliant D. QAPI committee will review audits monthly x's 3 months than included for review during quarterly QAPI meeting to	

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F 808	Continued From page 36 Observations and interviews revealed the following: 4/2/19 2:30 PM - During an interview, R70 stated he/she was supposed to be on extra Protein, but has not been receiving it. R70 stated that he/she has experienced weight loss recently, but has had a loss of taste and does not always like the food. R70 stated he/she was trying to eat more, but can't always do it. R70's meal ticket stated, "Provide Large Portion Entree (Protein) at meals." 4/3/19 8:56 AM - R70 was about to start eating breakfast which consisted of a bowl of oatmeal to which he/she added milk, 1 scoop of scrambled eggs, a small cinnamon muffin, and a cup of coffee. 4/5/19 8:52 AM - R70 had eaten breakfast, which consisted of one (1) pancake, one (1) sausage link, a bowl of oatmeal with added milk, and a cup of coffee. R70 ate all of the breakfast except for a small amount of oatmeal. 4/8/19 8:25 AM - R70 was served breakfast which consisted of one (1) scoop of scrambled eggs, one (1) slice of white toast with no butter or jelly, a bowl of oatmeal with milk added, and a cup of coffee. 4/8/19 9:43 AM - R70 was observed to have eaten all of the scrambled eggs, 1/2 of the oatmeal, and a 1/2 slice toast. R70 stated the toast was "too dry, no butter." 4/11/19 8:45 AM - R70 was observed eating breakfast, which consisted of one (1) scoop of scrambled-like eggs with cheese, one (1) cinnamon bun, milk, coffee, and a bowl of	F 808	identify trends	

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F 808	Continued From page 37 oatmeal. 4/11/19 12:20 PM - R70 was observed being served lunch. R70 received a bowl of soup, a regular 1/2 portion of a submarine (sub) sandwich, and approximately 1/2 cup cucumber salad. The sub consisted of one (1) slice of ham, one (1) slice salami/pepperoni, lettuce and one (1) slice of tomato. 4/11/19 at approximately 2:00 PM - During an interview with E15 (FSD), findings were reviewed. E15 confirmed that 1 scoop of eggs and 1/2 of a sub was not considered "Large Portion." E15 stated the eggs would be 1 and 1/2 scoops, and for the sub it would be 3/4's of the whole sub, but since the subs were cut in halves, he would give two portions of the half subs. The facility failed to provide large entree portions at meals for R70 according to the physician's order. Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 4/17/19 at approximately 2:45 PM.	F 808		
F 809 SS=E	Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and	F 809		6/5/19

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F 809	Continued From page 38 breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: Based on interview, it was determined that the facility failed to ensure snacks were offered to residents at bedtime when there were more than fourteen (14) hours from dinner to breakfast the following day. Findings include: 1. During the resident council meeting with surveyors on 4/8/19 at 4:00 PM, two (2) out of eighteen (18) residents in attendance stated they were not being offered bedtime snacks routinely. 2. R43 stated on 4/15/19 at 5:50 PM, that he/she liked getting snacks at bedtime. On the evenings he/she was not offered a snack, R43 went to nursing to ask for one. 3. R42 stated on 4/15/19 at 6:00 PM that the requested snack at bedtime of a peanut butter sandwich, at times, came as plain bread with peanut butter on the side, peanut butter alone with no bread, bread with no peanut butter, or none at all. 4. R11 stated on 4/17/19 at 9:05 AM, that he/she was not being offered a bedtime snack routinely.	F 809	A/B. All residents have the potential to be affected by this deficient practice C. A root cause analysis has been completed to determine the cause of the deficient practice C. Based on the root cause analysis, substantial snacks will be available and offered to all residents during the evening hours Food Service Director or designee will reinservice the dietary staff on providing substantial snacks to the nursing units so snacks can be available and offered to the residents in the evening C. Nurse Practice educator or designee will reinservice all nursing staff on the policy for offering all residents a substantial snack in the evening that will include the documentation of snacks offered. D. Center Nurse Executive or designee will ask a minimum of 4 residents per unit	

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F 809	Continued From page 39 These findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 4/17/19 at approximately 2:45 PM.	F 809	daily x 's 2 weeks to determine that residents were offered a evening snack. Once 90% or greater compliant, audits will be completed weekly x s 4 weeks as long as 100% compliance is maintained during the 4 weeks, than monthly x s 3 months until 100% or greater compliance is maintained D. QAPI committee will review audits monthly x's 3 months than included for review during the quarterly QAPI meeting to identify trends	
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 observations and interview, it was	F 812	A/B. All residents have the potential to be	6/5/19

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F 812	Continued From page 40 determined that the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety. Findings include: 1. Observations of meal service from the portable steam food cart revealed the following: 4/2/19 12:15 PM - E13 (Dietary Aide) was observed serving the 600 wing from the portable steam food cart. E13, while gloved, touched various surfaces on the steam cart such as lids, drawers, serving utensils, and then with the same gloved hands reached into a container with cornbread and placed it on residents plates. E13 removed the contaminated gloves, then gloved again without performing handwashing first and resumed plating food in the same manner. 4/2/19 12:40 PM - E13 (Dietary Aide) was observed pushing the steam cart down the hallway to the 100 wing. E13 then gloved without first performing handwashing and proceeded to plate the food. 4/5/19 12:15 PM - E13 was observed plating food from the steam cart on the 500 wing. E13 was wearing gloves and touching various items, such as utensils and lids. E13 was observed reaching inside a bag of rolls with the gloved hand placing rolls on the plates. 4/8/19 8:20 AM - E4 (Dietary Aide) and E14 (Dietary Aide) were observed wearing gloves while pushing the steam cart down the 500 wing. While wearing the same gloves, E4 lifted a stack of clean plates after opening a drawer with the gloved hands and then began plating food. E14 delivered plates to room 502, came out of the	F 812	affected by this deficient practice C. Root cause analysis was completed to identify the cause of the deficient practice C. Based on the root cause analysis, the Food Service Director or designee will reinservice all dietary staff on infection control, including handwashing, with food service C. Based on root cause analysis a Handwashing Sign will be put in place next to sink C. Based on the root cause analysis, all dietary staff will be reinserviced on the cleaning of the food thermometer between foods and after contamination C. Food Service Director or designee will reinservice all dietary staff concerning keeping the flour and all other items in the pantry covered or wrapped when not being used or accessed. C. Food Service Director or designee will reinservice all staff about not entering the kitchen unless wearing a proper hair restraint D. Food Service Director or designee will conduct daily audits for all three meals x s 2 weeks to determine that dietary staff are maintaining proper infection control practices when serving and preparing food. Once 100% compliant, audits will be completed weekly x s 4 weeks. Once the weekly audits achieve	

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F 812	Continued From page 41 room, lifted the lid off of the oatmeal and plated some oatmeal while wearing the same gloves throughout. E4 while still wearing the same gloves and handled toast and placed it on a plate. 4/10/19 8:21 AM - E13 was observed delivering the steam cart to the 600 wing and plugging it into a wall outlet. E13 gloved without handwashing first and delivered plated food to residents. E4 was observed wearing gloves and touching lids, then touching biscuits and sausage (not using utensils) with gloved hands. and placing them on resident's plates. E4 was also observed taking a cereal bowl out of a drawer and touching the inside food contact surface of the bowl with the contaminated gloved hand. 4/10/19 8:25 AM - E4 was observed removing his gloves, unplugging the steam cart, pushing it to the 500 wing and plugging it into a wall outlet. E4 did not complete handwashing, reapplied gloves and resumed plating in the 500 unit, without hand washing. 4/10/19 9:00 AM - E4 was observed pushing the steam cart down the hall and stopping at the entrance to the assisted dining room while wearing gloves. E4 removed the gloves, went to the kitchen door and punched in the code to enter the kitchen. A short time later, E4 came out with a tray full of scrambled eggs and placed it on the steam cart. E4 then pushed the steam cart to the 100 wing, plugged it into a wall outlet, gloved without completing handwashing first and began plating food. 4/10/19 12:14 PM - E13 was observed plating food on the 600 wing with gloved hands then reaching into a bag of rolls with the gloved hand	F 812	100% compliance that monthly x s 3 months until 100% compliant D. QAPI committee will review audits monthly x's 3 months than included for review during the quarterly QAPI meeting to identify trends	

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F 812	Continued From page 42 and placing it on a plate. E13 wiped off spilled food from the top of the steam cart surface with his/her gloved hand. E13 discarded the gloves, went into a resident room after knocking, came back out, gloved and began plating food without first completing handwashing. E14 was observed gloved while pushing the steam cart and then delivering plates to rooms wearing the same gloves. Findings were reviewed with E15 (FSD) on 4/16/19 at approximately 2:00 PM. 2. Observation during the initial kitchen tour on 4/2/19 from 8:00 AM to 9:00 AM revealed the following: - An employee cup filled with a beverage without a lid or straw was placed on top of the beverage refrigerator; - An employee cup filled with a beverage without a lid or straw was placed on top of the tray line area; - No hand washing signage at the food preparation area hand sink. Findings were reviewed and confirmed by E15 (FSD) at on 4/2/19 at approximately 9:00 AM. 3. On 4/2/19 at approximately 12:00 PM, it was observed that E25 (CNA) walked through the kitchen without a hair restraint and dumped a cup of coffee into the hand sink by the west dining room entrance. E25 then came back several minutes later and walked through the food plating part of the kitchen to access the other side of the dining room without wearing a hair restraint. Findings were reviewed and confirmed by E15 on	F 812		

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F 812	Continued From page 43 4/2/19 at approximately 12:00 PM. 4. 4/10/19 at 7:45 AM: a. E13 (Dietary Aide) was observed putting eating utensils in clear bags with bare hands, placing the handles on the bottom of the bags. After moving the container of bagged utensils to one side, E13 proceeded to the ice machine and, taking the scoop outside the machine with a bare hand, scooped ice cubes into a container. Prior handwashing was not observed. b. During breakfast service on 4/10/19 at 9:13 AM on the 200 wing, E13 was observed delivering two uncovered breakfast plates from the portable steam cart to a room, followed by another uncovered plate to another resident. c. During lunch service on the 600 wing on 4/10/19 at 12:12 PM, E14 (Dietary Aide) was observed distributing lunch plates, uncovered, to residents. d. 4/16/19 at 7:43 AM: An open container of thickener was observed in the kitchen pantry. Additionally, at least three plate lids stacked on top of the portable steam table were observed to be dirty with food debris on surfaces. e. 4/16/29 at 7:55 AM: E26 (Cook) was observed wearing gloves as he/she wiped the counter by the steam wells with a towel dipped in a sanitizing solution. E26 removed the gloves and put on new ones without first handwashing. E26 proceeded to take the temperature of the hot breakfast items on the steam table. f. 4/16/19 at 8:15 AM: E26 dropped the thermometer being used to take the temperature	F 812		

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F 812	Continued From page 44 of hot foods on the floor. E26 picked up the thermometer, laid it on the counter and placed a couple of pans of food in the steamer before resuming taking temperatures. Between food items, E26 wiped the probe with a paper towel. g. 4/16/19 at 8:40 AM: E4 (Dietary Aide) unplugged the portable steam cart wearing gloves at the end of plate distribution on the East wing and pushed the cart toward the West wing, stopping by the dining room to pick up a pan of pancakes from the kitchen. E4 was observed manually picking up a stack of pancakes and putting the pancakes on a resident's plate, wearing the same gloves. h. 4/16/19 at 9:43 AM: A large uncovered container of flour was observed in the kitchen pantry. At 10:30 AM, the container remained uncovered. These findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 4/17/19 at approximately 2:45 PM.	F 812		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records.	F 842		6/5/19

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F 842	Continued From page 45 §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches	F 842		

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F 842	Continued From page 46 legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and interviews, it was determined that for one (R46) out of 56 sampled residents, the facility failed to maintain accurate medical records in accordance with accepted professional standards and practices for CNA toileting documentation. Findings include: Review of R46's clinical record revealed the following: R46 was admitted to facility on 1/30/19. The admission MDS, completed 2/6/19, indicated that R46's ADL status was total dependence. R46 had moderate cognitive impairment (decisions poor; cues/supervision required). The incontinence assessment titled "Urinary Incontinence Nursing Interventions" on 2/5/19, completed by E10 (UM) indicated "Check and change at least q (every) 2 hours" after R46 declined to proceed with being taken to the	F 842	A. R46 had no negative outcome as a result of the facility's failure to maintain accurate medical records in accordance with accepted professional standards and practices for CNA toileting documentation B. All residents identified as check and change have the potential to be affected by this deficient practice C. Root cause analysis was completed to identify the cause of the deficient practice C. Based on the root cause analysis, the Nurse Practice Educator or designee will reinservice all nursing assistants on the proper way to document on residents identified as check and change D. Center Nurse Executive or designee will conduct audits daily of four residents resident from each unit x s 7 days to insure the residents identified as check	

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F 842	Continued From page 47 bathroom or using any toileting devices, such as a bedside toilet. . In the CNA documentation for "Device used for Bladder Continence" for the month of March, there were 15 out of 48 total opportunities that the facility documented R46 used a toilet. In the months of February and March 2019, there was a multitude of documentation of R46 using a "toilet" although R46 declined to use the toilet and was a every 2 hour check and change for continence. Findings were reviewed and confirmed with E2 (DON) on 4/15/19 at approximately 10:30 AM.	F 842	and change are being documented appropriately. Once 100% compliant than audits will be conducted weekly x s 4 weeks. If 100% compliance is maintained for the 4 weeks of audits than the audits will be conducted monthly x's 3 months until 100% compliant D. QAPI committee will review audits monthly x's 3 months than include for review during quarterly QAPI meeting to identify trends	
F 849 SS=D	Hospice Services CFR(s): 483.70(o)(1)-(4) §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet	F 849		6/5/19

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	085042	A. BUILDING _____ B. WING _____	04/17/2019

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F 849	Continued From page 48 professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice	F 849		

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F 849	Continued From page 49 representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation. (K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff. §483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible	F 849		

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F 849	Continued From page 50 for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident. The designated interdisciplinary team member is responsible for the following: (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system.	F 849		

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F 849	Continued From page 51 (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by: Based on clinical record review and interview, it was determined that for 1 (R37) out of 2 sampled residents, the facility failed to ensure that hospice records were complete and readily accessible. Findings include: 1/13/15 - Review of the written agreement between the hospice provider and the facility included, but was not limited to, the following: - " ...3. Responsibilities of Hospice ... (e) Provision of Information. Hospice shall promote open and frequent communication with Facility and shall provide Facility with sufficient information to ensure that the provision of Facility Services under this Agreement is in accordance with the Hospice Patient's Plan of Care, assessments, treatment planning and care coordination. At a minimum, Hospice shall provide the following information to Facility for	F 849	A. R37 hospice record has been updated to accurately reflect the current plan of care in the hospice records as well as all other hospice documentation as required. B. All hospice residents will have their hospice records reviewed to insure that the hospice record accurately reflects the current plan of care in the hospice records as well as all other hospice documentation as required. C. Root cause analysis was completed to determine the cause of the deficient practice C. Based on the root cause analysis, the center will begin reviewing the hospice	

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F 849	Continued From page 52 each Hospice Patient residing at Facility: (i) Plan of Care, Medications and Orders. The most recent Plan of Care, medication information and physician orders specific to each Hospice Patient residing at Facility; (ii) Election Form ... (iii) Certifications. Physician certifications and recertifications of terminal illness; ... 6. Records ... (a) Creation and Maintenance of Records. Each party shall prepare and maintain complete and detailed records concerning each Hospice Patient receiving Facility Services under this Agreement in accordance with prudent record-keeping procedures and as required by applicable federal and state laws and regulations and Medicare and Medicaid program guidelines ...Each clinical record shall completely, promptly and accurately document all services provided to, and events concerning, each Hospice Patient, including evaluation, treatments, progress notes, authorizations to admission to Hospice and/or Facility, physician orders entered pursuant to this Agreement and discharge summaries. Each record shall document that the specified services are furnished in accordance with this Agreement and shall be readily accessible and systemically organized to facilitate retrieval by either party ...". Review of R37's clinical record revealed: 4/8/19 - Review of R37's hospice binder located in the nurse's station lacked evidence of the following: - Most recent Plan of Care and Medication List; - Hospice Election Form; - Physician Certifications and Recertifications of terminal illness; In addition, the hospice clinical record lacked	F 849	records on a regular basis to determine if the hospice records are current. Hospice will be notified if records are not current to bring record current D. Center Nurse Executive or designee will conduct audit of the record of one hospice patient per week x' s 4 weeks until 100% compliant. Once 100% compliant than all hospice records will be audited monthly x' s 3 months until 100% compliant D. QAPI committee will review audits monthly x's 3 months than included for review during quarterly QAPI meting to identify trends	

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F 849	Continued From page 53 evidence of the hospice physician's notes regarding R37. 4/8/19 at 8:13 AM - During an interview, E2 (DON) confirmed that all of the hospice documentation was in the hospice binder in the nurse's station. 4/8/19 at 11:26 AM - During a combined interview, H2 (RN Case Manager) and H3 (Associate Team Director) brought copies of R37's most recent plan of care, medication list and the most recent physician recertification of terminal illness. 4/8/19 at 3 PM - H3 returned to the facility with additional hospice documentation, including copies of all the physician recertifications, nursing assessments, and the hospice physician's notes. 4/10/19 at 4:30 PM - Findings were reviewed with E1 (NHA) and E2 (DON). The facility failed to ensure that R37's hospice records were complete and readily accessible.	F 849		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention	F 880		6/5/19

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F 880	Continued From page 54 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 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	F 880		

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F 880	Continued From page 55 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 observations and interviews, it was determined that the facility failed to maintain an infection control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable disease and infections. Observation of one (R88) out of 2 sampled residents, during a wound treatment revealed that facility staff failed to complete adequate hand hygiene on seven (7) occasions. Findings include: According to CDC (Centers For Disease Control And Prevention) Guideline for Hand Hygiene in Healthcare Settings published in 2002, " ...Hand Hygiene is indicated: 1. When hands are visibly dirty, contaminated, or soiled, wash with non-antimicrobial or antimicrobial soap and water and 2. If hands are not visibly soiled, use an alcohol - based hand rub for routinely decontaminating hands. Hand Hygiene is specifically indicated: Before: patient contact, donning gloves when	F 880	A. R88 had no negative outcome as a result of the deficient practice B. All residents have the potential to be affected by this deficient practice C. A root cause analysis was completed to determine the cause of the deficient practice C. Based on the root cause analysis, the Nurse Practice Educator will reinservice all nurses on the proper technique for maintaining infection control during a dressing change, including hand hygiene D. Center Nurse Executive or designee will watch one dressing change per week x 's 4 weeks to insure the proper infection control technique, including hand hygiene, is being used during dressing changes. Once the weekly audits are 100% compliant than audits will be	

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F 880	Continued From page 56 inserting a CVC (Central Venous Catheter), inserting urinary catheters, peripheral catheters, or other invasive devices that don't require surgery After: contact with a patient's skin, contact with body fluids or excretions, non-intact skin, wound dressings and removing gloves ..." On 4/4/18 at 10:49 AM - E10 (RN) was observed administering wound care on R88's left heel. E10 did not wash her hands before beginning to remove R88's old left heel dressing. With the same used gloves, E10 continued to cleanse the left heel wound and applied a dry dressing. E10 removed his/her old gloves and put on a new pair as he/she rolled and positioned R88 on the left side to prepare for the buttocks treatment. Wearing the same gloves, E10 squeezed a good amount of calazime paste into the dry gauze. E10 stated that he/she needed more calazime paste, and with 1 gloved hand, E10 opened the top and lower bedside drawers and searched for more tubes. E10 stated that he/she also needed a washcloth, so he/she went and opened the bathroom door using the same gloved hand. E10 proceeded to change gloves, then proceeded to cleanse the buttocks area with saline and applied calazime paste. E10 changed gloves again to put on a fresh incontinence brief for R88. E10 gathered all the trash and soiled linen, removed his/her gloves and began washing his/her hands in the bathroom sink. Prior to this, E10 did not perform handwashing between glove changes. A soiled washcloth was noted on the right hand side of the sink. E10 proceeded to wipe his/her hands dry with a paper towel. With his/her right hand, E10 grabbed another paper towel to turn the faucet off. With the same paper towel in his/her right hand, and with no gloves, E10 picked up the soiled washcloth from the sink and carried the	F 880	conducted monthly x s 3 months until 100% compliant D. QAPI committee will review audits monthly x's 3 months than included for review during the quarterly QAPI meeting to identify trends	

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F 880	Continued From page 57 soiled washcloth out of R88's room, across the hallway and into the dirty utility room where soiled linens were placed. 4/4/18 at 11:35 AM - During an interview when asked why E10 did not wear gloves when he/she picked up the soiled washcloth from the sink after E10 washed her hands, E10 stated that he/she did not perform hand washing prior to changing gloves during R88's wound care because, "I used the paper towel as a shield between my right hand and the washcloth." Findings were acknowledged by E10. Findings were reviewed with E1 (NHA) and E2 (DON) during the Exit Conference on 4/17/2019 beginning at 2:45 PM.	F 880		

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) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Brackenville Center **DATE SURVEY COMPLETED: April 17, 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 and Emergency Preparedness survey was conducted at this facility beginning April 2, 2019 through April 17, 2019 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 101.		
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 April 17, 2019 F550, F641, F642, F645, F656, F657, F684, F688, F689, F690, F725, F755, F761, F804, F808, F809, F812, F842, F849 and F880.	Cross reference plan of correction for CMS 2567 for Annual survey ending April 17, 2019 F550, F641, F642, F645, F656, F657, F684, F688, F689, F690, F725, F755, F761, F804, F808, F809, F812, F842, F849 and F880	

Provider's Signature _____ Title Center Executive D.V Date 8/15/19

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NAME OF FACILITY: Brackenville Center **DATE SURVEY COMPLETED: April 17, 2019**

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	Abbreviations/definitions used in this report are as follows: DON – Director of Nursing; eMAR – electronic Medication Administration Record; NHA – Nursing Home Administrator; **Services to Residents** **Communicable Diseases** **Specific Requirements for Tuberculosis** **The facility shall have on file the results of tuberculin testing performed on all newly placed residents.** **This requirement is not met as evidenced by:** Based on clinical record reviews and interview, it was determined that for 2 out of 6 sampled residents, the facility failed to ensure the residents received the Tuberculosis 2-step testing. Findings include: 1. Review of R73's clinical record revealed: 3/6/19 – R73 was readmitted to the facility. 3/6/19 – Review of the March 2019 eMAR revealed that R73 was administered the 1st step on 3/6/19 and results were read on 3/9/19.	R 90 was discharged on 4/7/2019 R73 will receive the Tuberculosis 2 Step testing All newly admitted or readmitted residents since April 1st 2019 will have the records reviewed to determine if the Tuberculosis 2-step testing was completed according to the policy. Root cause analysis was completed to determine the cause of the deficient practice Based on the root cause analysis, Nurse Practice Educator or designee will reinservice all licensed nurses on the policy for Tuberculosis 2-step testing of residents and documenting the results Nurse Practice educator or designee will audit all new admits and readmits to determine that the Tuberculosis 2-step testing was completed and documented. Audits will be completed weekly x's 4 weeks. Once 100% compliant the audits will be completed monthly x's 3 months to maintain 100% compliance. QAPI team will review the audit results to identify any trends.	6/6/2019

Provider's Signature _____ Title _____ Date _____

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NAME OF FACILITY: Brackenville Center **DATE SURVEY COMPLETED: April 17, 2019**

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	3/19/19 – Review of the March 2019 eMAR revealed that R73's 2nd step was "In Progress". The eMAR lacked evidence that the 2nd step was administered and results read. 2. Review of R90's clinical record revealed: 12/7/18 – R90 was admitted to the facility. 12/7/18 – Review of the December 2018 eMAR revealed that R90 was administered the 1st step on 12/7/18. The facility lacked evidence that R90's 1st step test result was read and the 2nd step was administered and test result read. 4/10/19 at 4:30 PM – Findings were reviewed with E1 (NHA) and E2 (DON). The facility failed to ensure 2 resident received the Tuberculosis 2-step testing.		

Provider's Signature _____ Title _____ Date _____