STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085026	A. BUILDING _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEGATES	4031 KENNETT PIKE GREENVILLE, DE 19807

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced annual survey was conducted at this facility from May 30, 2019 to June 10, 2019. The facility census the first day of the survey was 36. During this period, an Emergency Preparedness survey was also conducted by the State of Delaware's Division of Health Care Quality, Office of Long Term Care Residents Protection in accordance with 42 CFR 483.73. For the Emergency Preparedness survey, no deficiencies were cited.	E 000		
F 000	INITIAL COMMENTS Report revised following CMS CMP review 7/26/19 F677 deleted. Text changes made to F689 following IDR. Provider letter revised 7-22-19 An unannounced annual and emergency preparedness survey was conducted at this facility from May 30, 2019 to June 10, 2019. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census the first day of the survey was 36. The survey sample size was 24. Abbreviations used in this report are as follows: ADL (activities of daily living) - tasks needed for daily living, e.g. dressing, hygiene, eating, toileting, bathing; a/p - assessment/plan; ADON - Assistant Director of Nursing; Antipsychotic - class of medication used to manage psychosis, an abnormal condition of the	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/28/2019

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

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F 000	Continued From page 1	F 000		

mind involving a loss of contact with reality and other mental and emotional conditions;
Anxiety - general term for several disorders that cause nervousness, fear, apprehension and worrying;
Arthropathy - disease of a joint;
BIMS (Brief Interview for Mental Status) - assessment of the resident's mental status. The total possible BIMS Score ranges from 0 to 15 with 15 being the best:
0-7: Severe impairment (rarely/never made decisions)
8-12: Moderately impaired (decisions poor; cues/supervision required)
13-15: Cognitively intact (decisions consistent/reasonable);
Bipolar Disorder - mood disorder;
CNA - Certified Nurse's Aide;
Cognitively Impaired - mental decline including losing the ability to understand, the ability to talk or write, resulting in the inability to live independently;
Dementia - loss of mental functions such as memory and reasoning that is severe enough to interfere with a person's daily functioning;
DHCQ-Division of Health Care Quality;
DON - Director of Nursing;
Efficacy - the ability to produce a desired or intended result;
eMARs - electronic Medication Administration Records/list of medications to be administered;
Femur - thigh bone;
Fracture - a broken bone;
Gait - Manner or style of walking;
LPN - Licensed Practical Nurse;
mg - milligram/unit of weight;
MRR - Medication Regimen Review;
Namenda - a drug used to treat dementia;
NHA - Nursing Home Administrator;

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F 000	Continued From page 2 Orthopedic - the branch of medicine dealing with bones; Psychotic features - term that describes a mood episode that also has the presence of delusions or hallucinations; Psychotropic - any medication capable of affecting the mind, emotions and behavior; pt - patient; PT - Physical Therapy; Pubic ring - a ring of bones that connect the legs to the torso; Risperdal - antipsychotic medication used to manage psychosis; RN - Registered Nurse; Schizophrenia - mental disorder with false beliefs of being harmed; Seroquel - an antipsychotic medication; Sertraline - an antidepressant medication; X-ray - picture taken of bones or organs; Zoloft - medication used to treat depression.	F 000		
F 689 SS=G	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, interview, and review of facility documentation, it was determined that for one (R31) out of three residents sampled for accidents, the facility failed to ensure that the resident received adequate	F 689	1. A trained C.N.A. was caring for R-31 in the resident's room and the bathroom on both 11/2/18 and on 5/11/19. Each fall was reviewed, protocol followed and care plans were updated as appropriate.	7/22/19

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F 689	Continued From page 3 supervision to prevent accidents. R31 had a history of falls and was impulsive with poor safety awareness. The facility failed to ensure that R31 received adequate supervision to prevent falls on 11/2/18 and 5/11/19 that resulted in harm to R31. On 11/2/18, R31 was harmed when the facility failed to provide adequate supervision resulting in R31 falling and sustaining a right pubic ring fracture. On 5/11/19, R31 was harmed when the facility failed to provide adequate supervision resulting in R31 falling and sustaining a wound to the back of the head that required staples for closure. Findings include: Review of R31's clinical record and facility documents revealed: 2001 (revised March 2018)- The facility's policy entitled, Falls and Fall Risk, Managing, stated, "...Resident-Centered Approaches to Managing Falls and Fall Risk 1. The staff, with the input of the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls... Monitoring Subsequent Falls and Fall Risk... 2. If interventions have been successful in preventing falling, staff will continue the interventions or reconsider whether these measures are still needed... 3. If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions..." 11/1/17- R31 was admitted to the facility. 11/2/17- A care plan was initiated stating that R31 was at high risk for falls related to gait balance problems and dementia. Interventions included	F 689	2. All residents at high risk for falls will have care plans evaluated and reviewed for updated interventions and resolutions if indicated. The facility will always strive to honor residents preferences and choices as noted on their plan of care as well as addressing safety concerns. Interventions that are in place will continue to be monitored and removed or revised as a part of incident investigation. 3. All nursing staff will be educated on falls and fall risk, adding interventions and honoring person centered care. All investigations will follow the five whys. An anti-roll back device with alarm will be utilized for R31 to reduce the risk of the wheelchair rolling back if an attempt is made to stand. This device is attached to the chair so it is obvious that it will always be in use. This intervention will be used when indicated. Assistive devices in use at the time of the fall will be evaluated by nursing and therapy in an attempt to eliminate or minimize the hazard. The Post Fall Analysis will be updated to include the status of the assistive devices used to include the unlocking/locking of the wheelchair. 4. The DN/designee will review all falls on a daily basis and complete a thorough event analysis to ensure the fall protocol is being followed and the plan of care is revised as necessary for each fall. Fall data will be analyzed and evaluated daily by the DN/designee times 30 days, and then weekly for 8-weeks and then monthly	

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F 689	Continued From page 4 that R31 used a wheeled walker to ambulate and staff were to supervise. 11/2/17- A care plan was initiated stating that R31 had impaired cognitive function and thought processes related to dementia. Interventions included to cue, reorient and supervise R31 as needed. 11/2/17- A care plan was initiated stating that R31 had an ADL self-care performance deficit related to dementia and impaired balance. Interventions included that R31 used a wheeled walker and required supervision, and may require contact guard (have one or two hands on the person's body to help with balance) if unsteady. 11/3/17- R31's care plan revealed a fall. 11/2/17- The intervention "resident educated on bed alarm for safety and agrees" was added to R31's fall care plan. 11/3/17- The intervention "remind resident to call for assistance and to wait for staff before trying to get up" was added to R31's fall care plan. 1/3/17 to 9/15/18- Review of R31's fall care plan indicated that R31 fell on 9/5/18, 9/14/18, and 9/15/18. 8/10/18- A quarterly MDS assessment listed R31's BIMS (Brief Interview for Mental Status) score as "10" which indicated moderate cognitive impairment (decisions poor; cues/supervision required). No behaviors were coded. R31 was coded as one person limited assistance with transfers (how resident moves between surfaces including to or from: bed, chair, wheelchair,	F 689	for 12 months until 100% compliance is achieved. A summary of the event analysis and monthly data reports will be submitted to the QAPI committee for review and recommendations.	

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F 689	Continued From page 5	F 689		

standing position) and toilet use (includes how the resident uses the bathroom and transfers on/off the toilet). The MDS indicated that R31 had no falls since admission/reentry to the facility.

9/16/18- A progress note documented that R31 was "noted to be impulsive" as he/she attempted to "stand without any assistance." It was noted that R31 was reminded to wait for assistance for safety to "prevent fall."

10/12/18 to 10/31/18- Review of R31's care plan indicated that R31 had additional falls on 10/12/18 and 10/31/18.

11/2/18 1:15 AM- Review of an incident report revealed that R31 called for assistance to use the bathroom and the CNA immediately responded. The CNA assisted R31 up from his/her bed and walked R31 via his/her walker to the bathroom. R31 became weak and began lowering him/herself to the floor, but the CNA caught R31 and called for help. It was noted that from the incident report that R31 reopened "old bruises" on his/her left top hand and right elbow.

11/2/18- Review of a statement form revealed that E6 (CNA who assisted R31 to the bathroom) stated that she got R31 out of bed and walked him/her to the bathroom. Once at the toilet, R31 pulled down his/her pants. E6 let go of R31 to get gloves and as E6 turned around, R31 was falling. E6 stated that she caught R31 and lowered him/her to the floor.

11/2/18 7:15 AM- Review of an incident report revealed that E15 (LPN) responded to R31's room after hearing a "startled shriek" from E7 (CNA). Upon entering the resident's room, R31

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F 689	Continued From page 6 was noted to be sitting on his/her buttocks on the bedroom floor next to his/her bed. R31's walker was noted to be next to R31 and within his/her reach. R31 was assessed and no major injuries were noted at that time. It was noted that E7 (CNA who witnessed the fall) completed a statement form that stated R31 was "very impulsive with poor safety awareness, 2 person hands on assistance used for transferred (sic) post this fall." A care plan addressing R31's impulsiveness and poor safety awareness was not initiated to prevent additional falls. 11/2/18- Review of a statement form revealed that E7 (CNA) stated that she was taking R31 to the bathroom and noticed that he/she was "a bit unsteady" and asked if he/she wanted the wheelchair. R31 said yes, and E7 quickly went to get it (Additional information supplied by the facility revealed that the wheelchair was within a 5 feet reach) and R31 fell. 11/2/18- Review of R31's care plan indicated that R31's fall care plan was revised to include his/her falls on 11/2/18. Interventions were revised to include that R31 was to have two people with transfers, to have R31 attend programs in the living room and eat meals in the dining room to help with supervision, and for PT to evaluate and treat. 11/2/18 4:30 PM- A progress note documented that R31 continued with poor safety awareness and continued to be impulsive. R31 was noted to be transferred with two person hands on assistance, and was leaning forward with transfers, and needed prompting to stand up straight.	F 689		

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F 689	Continued From page 7 11/3/18 1:35 PM- A progress note documented that R31 received Tylenol for pain to his/her right leg when being toileted. 11/3/18 2:29 PM- A progress note documented that R31 was unable to lift his/her lower extremities, as well, when he/she was standing and walking. It was noted that R31 was very unsteady. 11/3/18 10:14 PM- A progress note documented that after the fall (second fall on 11/2/18), R31 was not standing well or turning his/her right leg. R31 also pointed to his/her right hip area and stated that he/she had pain. R31's difficulty with transfers was reported to the supervisor. 11/3/18 10:30 PM- A progress note documented that the physician was notified about R31's pain to his/her right hip post fall. A physician's order was entered for R31 to receive an x-ray of his/her right hip, pelvis, and femur to rule out broken bones. 11/4/18 10:41 AM- A progress note documented that R31's x-ray was obtained. 11/4/18 2:57 PM- Review of R31's x-ray results revealed that R31 had a recent right pubic ring fracture. 11/4/18 5:25 PM- A progress note documented that the physician was notified of R31's x-ray results and ordered for R31 to receive orthopedic and PT consults. The physician suggested that R31 be non-weight bearing to his/her right leg until further evaluation. 11/6/18 11:35 AM- A physician progress note	F 689		

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F 689	Continued From page 8 documented that R31 had "high impulsivity and lack of safety awareness ...Plan: ...Will need to be supervised during day now and not stay room (sic) unsupervised." 11/8/18- A significant change in status MDS assessment listed that R31's BIMS score as "9", which indicated moderate cognitive impairment (decisions poor; cues/supervision required). In addition, the MDS revealed that R31 required two+ persons with extensive assistance for transfers and toilet use in response to the fracture. R31 returned to pre fracture status as far as requiring one-person assistance, however, R31 needed limited assistance pre fracture and now required extensive assistance. 11/12/18 11:45 PM- R31's orthopedic consult stated that R31 could be weight bearing as tolerated and ordered a follow up in 6 weeks with a repeat pelvis x-ray. 12/13/18 10:44 PM- A progress note documented that R31 continued to stand on impulse when staff was not ready or reach out for things in a "hurry". 12/17/18 11:24 AM- Review of R31's repeat pelvic x-ray revealed his/her right pubic ring fracture was healing. 1/30/19 7:30 AM- Review of an incident report revealed that R31 fell trying to get out of bed unassisted without proper footwear, and hit his/her head. There was no significant injury documented from this fall. Review of R31's care plan revealed this fall was not included in R31's care plan and no new fall safety interventions were initiated.	F 689		

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F 689	Continued From page 9 2/8/19- A quarterly MDS assessment revealed that R31's BIMS score had decreased to a "3" (was a "10" on the 8/10/18 MDS assessment and a "9" on 11/8/18 MDS assessment), which indicated severe cognitive impairment (never/rarely made decisions). In addition, the MDS revealed that R31 was a one-person extensive assistance for transfers and toilet use. 4/28/19 11:18 AM- A progress note documented that R31 was ambulating with a CNA and nursing and was very impulsive requiring close supervision. 5/9/19- A quarterly MDS assessment revealed that R31's BIMS score remained at a "3" (0-7), which indicated severe cognitive impairment (decision making severely impacted). In addition, the MDS revealed that R31 remained a one-person extensive assistance for transfers and toilet use. 5/11/19 7:30 AM- Review of an incident report revealed that E8 (RN) was receiving report when she heard E14 (CNA) scream. The nurse went immediately to the room and R31 was on the floor in the bathroom bleeding profusely from a head wound. E14 stated that she left R31 in a wheelchair and turned to close the door when R31 got up from the wheelchair and fell onto the bathroom floor. 5/11/19- Review of a statement form by E8 (RN that prepared the incident report) revealed that E14 (CNA) was taking R31 to the bathroom. E14 left R31 "sitting in wheelchair by grab bar, wheelchair not locked. E14 reported she turned away to close bathroom door when resident got	F 689		

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F 689	Continued From page 10 out of wheelchair to stand resulting in loss of balance and fall backward with wheelchair moving away from resident hitting head during fall." 5/11/19 8:31 AM- A progress note documented that R31 was out of the facility at the hospital. 5/11/19 3:49 PM- A progress note documented that R31 returned to the facility from the emergency room at 2:30 PM. It was noted that R31's head wound now had 6 staples. 5/11/19- Review of a rehabilitation screen revealed that PT was asked to review R31's fall and the incident report. PT stated after the fall review, that all safety components were in place and had no recommendations at this time. 5/11/19 to 5/15/19- Review of R31's fall care plan revealed that the intervention of two person transfers, initiated on 11/2/18, was resolved/discontinued on 5/14/19. On 5/15/19, a statement was added to R31's fall care plan interventions/tasks section. It stated that R31 was "impulsive" and had "poor safety awareness." No new interventions were added to R31's care plan after his/her fall on 5/11/19 to prevent additional falls. 6/5/19 9:45 AM- During an interview, E9 (LPN) stated that R31 was never a two-person transfer and that staff always transferred R31 with one person. E9 stated that R31 always needed supervision when he/she was awake because R31 was impulsive. E9 stated that "if you turn your head, even for a minute" R31 would try to get up and might fall.	F 689		

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F 689	Continued From page 11 6/5/19 2:28 PM- R31 was observed in the bathroom in his/her bedroom with one staff member, E16 (CNA). After finishing in the bathroom, E16 wheeled R31 out of the bathroom into the hallway. E16 left R31 sitting in the hall by him/herself and went into the visitor/staff bathroom (where R31 was not visible to E16). E16 washed her hands, and went back out into the hallway after approximately 30 seconds and took R31 to the activity room. 6/5/19 at approximately 4:32 PM- Findings were reviewed with E2 (DON). 6/5/19 at approximately 4:45 PM- Findings were reviewed with E1 (NHA). 6/6/19 at 4:22 PM the facility provided a copy of a text message between the DON and E14 (CNA). The message said that E14 stated that she/he locked R31's wheelchair the day (5/11/19) she/he fell in the bathroom. The message continued to state that E14 thought that R31 unlocked her/his own wheelchair. E14 had witnessed her/him unlock the brakes before. The facility failed to ensure that R31, a resident known to be impulsive and lacking safety awareness, received adequate supervision to prevent accidents on 11/2/18 and 5/11/19 that resulted in harm. On 11/2/18, 6 hours after R31 had a previous fall, a staff member noted that R31 was "unsteady" and turned her back to R31 to get R31's wheelchair. R31 fell and sustained a right pubic ring fracture. After this fall, R31 was care planned to have two people during transfers temporarily. On 5/11/19, R31's wheelchair was unlocked (although resident was able to unlock the wheelchair according to facility documentation	F 689		

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F 689	Continued From page 12 sent to DHCQ (Division of Health Care Quality) after the survey), and the staff member turned away from R31 to shut the bathroom door. R31 stood up, fell, and sustained a wound to the back of his /her head that required staples. While the facility implemented interventions to have R31 attend programs in the living room and eat in the dining room to help with supervision, the aforementioned falls with harm were witnessed by a single staff member that was providing care to R31. Despite the presence of a continued decline in mental status, the presence of poor safety awareness, continued falls and the recognized tendency of the resident to stand and move without warning the facility failed to provide adequate supervision.	F 689		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical	F 756		7/22/19

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	085026	A. BUILDING _____ B. WING _____	C 06/10/2019

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F 756	Continued From page 13 director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure that a recommendation by the consultant pharmacist was reviewed and acted upon by the physician for one (R7) out of five sampled residents reviewed for medication review. Findings include: Review of R7's clinical record revealed: On 2/11/19, an MRR was completed by the consultant pharmacist for R7 with a recommendation to "provide a quarterly psychotropic progress note addressing Seroquel, sertraline, and Namenda. Resident had a dose increase of Seroquel in October 2018. Consider for any possible dosage reductions. If not indicated, please document contraindication for psychotropic dosage reduction." There was no response by the physician for this	F 756	1. R-7 diagnosis of dementia with psychosis was noted by the physician on 3/19/19 as well as comments regarding the Seroquel, Namenda, and Sertraline. 2. The Consulting Pharmacist reports monthly her findings and recommendations. All residents who have pharmacy recommendations made to the physician will be reviewed by the DON/designee for follow up and correction. 3. The pharmacy recommendations will be reviewed by the DON/designee with the physician to assure recommendations are addressed timely. The physician's response will be timely and included on the pharmacy recommendation form or in	

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F 756	Continued From page 14 recommendation found in the clinical record. On 3/12/19, an MRR was completed by the consultant pharmacist for R7 with the same recommendation as the 2/11/19 MRR. The 3/12/19 MRR was signed and dated by the physician on 3/19/19, and included comments regarding the consultant pharmacist's recommendation. On 6/5/19 at 11:00 AM, findings were confirmed and reviewed with E2 (DON). The facility failed to ensure that the attending physician reviewed the 2/11/19 pharmacist recommendation for R7 until 3/19/19.	F 756	the progress note. 4. Audits of the pharmacy recommendations will be conducted by DON/designee monthly and submitted to the QAPI committee for recommendations by the DON, MD and Pharm D. Once 100% compliance is consistently met the deficient practice will be deemed resolved. The Consulting Pharmacist will continue to include physician compliance in their monthly reports.	
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;	F 758		7/22/19

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F 758	Continued From page 15 §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview, review of the clinical record and facility documentation as indicated, it was determined that for 1 (R13) out of 2 sampled residents, the facility failed to ensure R13's clinical record accurately reflected the appropriate diagnosed condition for his/her antipsychotic medication, Risperdal. In addition, the facility failed to identify and monitor the appropriate targeted behavior(s) for which the Risperdal was prescribed. Findings include:	F 758	1. The diagnosis for R-13 was updated on June 5, 2019 2. All current residents receiving psychoactive drugs will have charts reviewed to assure proper diagnosis and monitoring of targeted behaviors is in place. 3. All licensed staff will be educated on	

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F 758	Continued From page 16 The facility's pharmacy policy entitled "Behavioral Assessment, Intervention and Monitoring", last revised Dec. 2016, stated, "...10. When medications are prescribed for behavioral symptoms, documentation will include: ...e. Specific target behaviors...h. Monitoring for efficacy...". Review of R13's clinical record revealed: 5/7/19 at 4:15 PM - A physician's note stated, "asked to see pt (patient) (sic) increase in behaviors and possibly psychotic features, is on zoloft 50mg daily...a/p behaviors with possible psychotic features I feel at this time may need to treat with low dose of antipsychotic as pt is exhibiting behaviors that be (sic) be detrimental to...well being (sic) will start risperidal (sic) in evening at 0.25mg." It was unclear in the physician's note of the targeted behavior(s) that needed to be monitored when Risperdal was ordered. 5/7/19 - The physician's order, handwritten by E5 (Physician), stated to give Risperdal 0.25mg by mouth daily at bedtime. The handwritten physician's order did not state the diagnosis for Risperdal, an antipsychotic medication. 5/7/19 - Review of the facility's electronic Order Recap Report, which listed all physician's orders from 1/1/19 through 6/3/19, stated to give Risperdal 0.25mg orally at bedtime for anxiety. The facility failed to accurately reflect R13's diagnosed condition for Risperdal. 5/7/19 - A facility form entitled "Consent for use of psychoactive medication therapy", completed by	F 758	confirming with physician proper indications when receiving orders for psychoactive drugs. This education will include reviewing behavior monitoring sheets for appropriate diagnosis, targeted behaviors and if indicated side effects. 4. Monthly audits will be conducted by the DON/designee to determine that all psychoactive medications have appropriate indication for use. These audits will be submitted to the QAPI committee for recommendations by the MD, DON, and Pharm-D. Once 100% compliance is consistently met the deficient practice will be deemed resolved. Compliance will continue to be reported by the Consulting Pharmacist in the monthly consulting report submitted to the DN/designee.	

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F 758	Continued From page 17 E4 (RN), stated, "Psychotropic Medication Ordered: Risperdal, Date 5-7-19, Specific condition to be treated: (checked) Generalized Anxiety Disorder...The proposed course of the medications is: (checked) Prolonged treatment...Telephone Consent...". The facility failed to accurately reflect R13's diagnosed condition for Risperdal. 5/7/19 at 10:44 PM - A nurse's note, written by E4 (RN), stated, "Contacted (family) this evening in regards to new order to start Risperidal (sic) and related behaviors. (Family) discussed understanding...reason for the new order. Consent given." 5/7/19 through 5/31/19 - Review of R13's Behavior Monthly Flow Sheet listed the following medications with their diagnoses: 1. Zoloft (also known as Sertraline) for diagnoses of depression/anxiety, and 2. Risperdal for diagnosis of anxiety. The listed behaviors that were being monitored were: anxiety and depression. The facility failed to identify and monitor the appropriate targeted behavior(s) for R13's Risperdal medication. 5/8/19 through 6/2/19 - The May 2019 and June 2019 eMARs stated that R13 was administered Risperdal medication at bedtime for anxiety. For 26 days, the facility failed to identify and clarify the inappropriate diagnosis of R13's Risperdal medication on the eMARs with the physician. 5/8/19 - R13 was care planned for using Risperdal related to anxiety, behavior management. The interventions included, but was not limited to: "...Monitor/record occurrence of for target behavior symptoms and document per	F 758		

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F 758	Continued From page 18 facility protocol." 6/3/19 - Review of the facility's pharmacy 2017-2018 Long Term Care Nursing Drug Handbook, located in the central Nurse's Station, revealed that Risperdal was a high risk medication used for the following diagnoses: schizophrenia and bipolar disorder. According to this Drug Handbook, anxiety was not listed as an appropriate diagnosis for the use of Risperdal. 6/5/19 at 8:25 AM - During an interview, E3 (ADON) reviewed R13's clinical record where the diagnosis for Risperdal was listed as anxiety. E3 acknowledged that anxiety was not an appropriate diagnosis. E3 stated that the physician's note indicated that Risperdal was ordered for psychotic features. When asked what was the targeted behavior(s) being monitored for Risperdal, E3 provided the facility's Behavior Monthly Flow Sheets, which listed anxiety and depression. 6/10/19 at 12:30 PM - During the Exit Conference, the finding was reviewed with E1 (NHA) and E2 (DON). The facility failed to do the following: - clarify R13's diagnosis for Risperdal after receiving the handwritten physician's order from E5 (Physician), which lacked a diagnosis; then transcribed the handwritten physician's order to R13's electronic physician orders listing an inappropriate diagnosis of anxiety for Risperdal, which was carried over to R13's May 2019 and June 2019 eMARs; and - failed to identify and monitor the appropriate targeted behavior(s) for R13's Risperdal medication.	F 758		

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

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

STATE SURVEY REPORT

NAME OF FACILITY: Stonegates **DATE SURVEY COMPLETED: June 10, 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 from 5/30/19 through 6/10/19. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census the first day of the survey was 36. The survey sample size was 24.		
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 June 10, 2019: F689, F756, and F758.		
3225.9.5	**Requirements for tuberculosis and immunizations:**		

Provider's Signature Kim M Carr Title Administrator Date July 24, 2019

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3225.9.5.2	**9.5.2 Minimum requirements for pre-employment require all employees to have a base line two step tuberculin skin test (TST) or single Interferon Gamma Release Assay (IGRA or TB blood test) such as QuantiFeron. Any required subsequent testing according to risk category shall be in accordance with the recommendations of the Centers for Disease Control and Prevention of the U.S. Department of Health and Human Services. Should the category of risk change, which is determined by the Division of Public Health, the facility shall comply with the recommendations of the Center for Disease Control for the appropriate risk category.** **This REQUIREMENT was not met as evidenced by:** Based on interview and review of facility documentation as indicated, it was determined that the facility failed to maintain an effective infection prevention and control program by failing to ensure tuberculin (TB) testing was completed pre-employment for 2 (E12 and E13) out of 10 sampled employees. Findings include: 1.E12's (RN) hire date was 12/15/18 and E12's first day in the facility was 12/15/18. The facility lacked evidence of a 2nd step TB testing. 2.E13's (CNA) hire date was 10/2/18 and E13's first day in the facility was 10/2/18. The 1st step TB testing was placed on 9/25/18 and read on 9/27/18, with negative results. The 2nd step TB testing was placed on 11/4/18 and read on 11/7/18, with negative results. The 1st and 2nd steps were performed 5 weeks apart, despite the CDC recommendation of performing the 2 steps 1 to 3 weeks apart.	Two step PPD's will be administered to E12 and E13. E12 provided the annual result of the PPD from her full time employer All two step PPD's will be given between 10 to 14 days. The two steps will be read and recorded accordingly. All new employees will receive a two step PPD and have the second step completed prior to starting work in the facility. New hire audits will be conducted monthly to determine the Two-step PPD process is followed and documented prior to start date. Audits of two step PPD's for new hires will be reviewed through the QAPI committee	Corrected July 22, 2019

Provider's Signature _____ Title _____ Date _____

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NAME OF FACILITY: Stonegates **DATE SURVEY COMPLETED: June 10, 2019**

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	6/10/19 at approximately 10:45 AM – During an interview, E2 (DON) confirmed the findings. 6/10/19 at 12:30 PM - Findings were reviewed with E1 (NHA), and E2 (DON) during the Exit Conference. The facility failed to perform the 2nd step TB testing for E12 and failed to follow the CDC recommendation of performing 1st and 2nd TB testing steps 1 to 3 weeks apart.		
16 Del. C.	**Health and Safety – Regulatory Provisions Concerning Public Health**		
Chap. 11	**Long-Term Care Facilities and Services**		
Subchap. IV	**Criminal Background Checks; Mandatory Drug Screening; Long-Term Care Facilities; Nursing Home Compliance with Title XIX of the Social Security Act.**		
§ 1144	**Influenza Immunizations** **(a) Nursing and assisted living facilities shall annually offer, beginning no later than October 1st through March 1st of the following year, onsite vaccinations for influenza vaccine to all employees with direct contact with patients at no cost and contingent upon availability of the vaccine.** **(b) The facility shall keep on record a signed statement from each employee stating that the employee has been offered vaccination against influenza and has either accepted of declines such vaccination.** **Employment will not be contingent on influenza vaccination.**		

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	This REQUIREMENT was not met as evidenced by: Based on review of facility documentation and interview, it was determined that for 2 out of 10 sampled employees, the facility failed to keep a signed statement from each employee accepting or declining the influenza vaccination. Findings include: The facility's policy entitled "Influenza Vaccine", last revised on August 2016, stated, "...1. Between October 1st and March 31st each year, the influenza vaccine shall be offered to...employees...2. Employees hired...between October 1st and March 31st shall be offered the vaccine within five (5) working days of the employee's job assignment...5. For those who receive the vaccine, the date of vaccination, lot number, expiration date, person administering, and the site of vaccination will be documented in the...employee's medical record...7. If an employee refuses the vaccine for reasons other than medical contraindication, this shall be documented on the Employee Informed Consent for Influenza Vaccine...". 1.E11 (CNA) was hired on 2/11/19. The facility lacked evidence of E11's signed statement either accepting or declining the influenza vaccination. 2.E14 (CNA) was hired on 10/2/18. The facility lacked evidence of E14's signed statement either accepting or declining the influenza vaccination. 6/10/19 at approximately 10:45 AM – During an interview, E2 (DON) confirmed the findings.	E11 and E14 chose not to accept flu vaccines for the 2019 flu season. All health care employees are offered the flu vaccine during the flu season All health care employees offered the flu shot will be required to sign the consent form if they choose to accept the flu vaccine or sign the declination portion of the form if the choose to decline. (Attachment -A). Any employee hired during the months of October 1 and March 1 of the following year will be offered the flu vaccine. Audits will be conducted during the coming flu season. Audits of flu consents and declinations will be reviewed through the QAPI committee.	Corrected: July 22, 2019

Provider's Signature _____ Title _____ Date _____