STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085032	A. BUILDING _____ B. WING _____	C 02/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMINSTER VILLAGE HEALTH	1175 MCKEE ROAD DOVER, DE 19904

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E 000	Initial Comments Revised report. An unannounced annual and complaint survey was conducted at this facility from February 6, 2019 to February 12, 2019. The facility census the first day of the survey was 59. During this period, an Emergency Preparedness survey was also conducted by the State of Delaware 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 An unannounced annual and complaint survey was conducted at this facility from February 6, 2019 through February 12, 2019. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and other facility documentation as indicated. The facility census the first day of the survey was 59. The survey sample totaled thirty-three (33). Abbreviations/Definitions used in this report are as following: NHA - Nursing Home Administrator; DON - Director of Nursing; RN - Registered Nurse; LNC - Licensed Nurse Coordinator; LPN - Licensed Practical Nurse; COTA/L - Certified Occupational Therapy Assistant/Licensed; MD - Medical Doctor; RD (Registered Dietitian) - A food and nutrition expert who helps individuals make smart dietary	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/01/2019

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		

and lifestyle choices;
SE - Staff educator;
SLP (Speech Language Pathologist) - A specialist who evaluates and treats patients with speech, language, cognitive-communication and swallowing disorders.

Auscultation - the action of listening to sounds from the heart, lungs, or other organs, typically with a stethoscope;
BIMS (Brief Interview for Mental Status) - test to measure thinking ability with score ranges from 00 -15.
13-15: Cognitively Intact
08-12 Moderately Impaired
00-07 Severe Impairment;
cc - cubic centimeter;
Dementia - condition that causes problems with his thinking, behavior, and memory;
enteral feeding tube- flexible tube going into the stomach for nutrition;
EPA (Environmental Protection Agency) - a governmental agency to protect the environment and health;
EPA approved disinfectant - if a product claims to disinfect or sanitize microbes on a surface or object, for example, a spray that claims to sanitize pedicure foot trays, it must have an EPA registration number and establishment number;
FSBS (Fingerstick blood sugar) - test to determine blood sugar;
Gastric residual volume - the volume of fluid remaining in the stomach;
Glucometer - provide readings by detecting the level of glucose in a person's blood.
LNC (Licensed Nurse Coordinator) - codes and coordinates resident assessment forms in the nursing home;
PRN -as needed.
Psychotic disorder - severe mental disorders that

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F 000	Continued From page 2 cause abnormal thinking and perceptions; MAR (Medication Administration Record) - record of medication given to the resident, may be electronic, (EMAR). MDS (Minimum Data Set) assessment - standardized assessment form used in nursing homes; mg - milligram; RAI - Resident Assessment Instrument (includes the MDS).	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.	F 550		3/29/19

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F 550	Continued From page 3 §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 observation and interviews, it was determined that the facility failed to provide care and services in a manner that promoted respect and dignity during meals for four (R1, R5, R27 and R42) randomly observed residents. Findings include: 1. During random dining observation on the Long Term Care dining room: 2/8/19 beginning at approximately 7:45 AM - R42, a resident with a recent known significant weight loss, was observed sitting alone at a table with a lidded cup containing water and watching other residents, in the dining room who were being served beverages and meals. There were total of 12 residents in the dining room, sitting at different tables. 2/8/19 at approxiamtely 8:15 AM - E6 (CNA) approached R42. E6 was asked if R42 required assistance with meals and E6 verbalized that R42 did not require staff assistance. E6 then proceeded to obtain oatmeal, which was placed in a cup from Dietary Aide (E10). E6 proceeded to add sweetener to the oatmeal and provided this to R42 and R42 began consuming the oatmeal independently, approximatelhy 30 minutes after the other residents were being	F 550	F550 □ Resident Rights-Exercise of Rights A. R42, R21, R48, R34, R5, R32, R1 and R27 currently reside in the facility and are being served their meals at the same time as the residents at their table. No ill effects were experienced by being served their meals at a different time. B. An audit of current residents in the Long Term Care dining room was completed to ensure that each resident on one table is being served their food at the same time during all three meals. C. Nursing staff and dietary staff will be re-educated to ensure that staff members will be present in the Long Term Care dining room to ensure that residents seated at one table will be served at the same time during all three meals. D. An audit of residents in the Long Term Care dining room will be completed by the Director of Nursing/designee weekly including weekends for 4 weeks until 100% compliance and then monthly for 2 months until 100% compliance to ensure that each resident on one table is being	

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F 550	Continued From page 4 served. 2. During random dining observation on the Long Term Care dining room: 2/6/19 at 12:15 PM - An interveiw with R1 and R32 revealed "we wait a long time between servings for our meals." "It makes me feel bad if I have my meal before R32 and R21, so I wait for them and my meal gets cold." "Sometimes R32 gets hers first and sometimes I get mine first, but we still just sit here looking at the other one who has their plate". Long Term Care Dining room Observation: - 2/06/19 12:30 PM - R32 recieved meal. - 2/06/19 12:30 PM - R21 received meal. - 2/06/19 12:44 PM - R1 received meal, 14 minutes after his/her table mates. - 2/06/19 12:35 PM - R48 recieved meal. - 2/06/19 12:37 PM - R34 recieved meal. - 2/06/19 12:44 PM - R5 recieved meal, 9 minutes after his/her table mates. 3. The following was reviewed in R27's record and observed during random dining observation in the Long Term Care dining room: 6/25/18 - R27 was admitted to the facility. 1/2/19 - MDS assessment documented the R27 was moderately cognitively impaired. 2/6/19 12:11 PM - An observation of CNA's noted to be asking residents whether they would like clothing protector and beginning to serve the lunch time meal. 2/6/19 12:52 PM - R27 observed without lunch and surveyor asked E12 (CNA) why R27 was not	F 550	served their food at the same time. All audit results will be forwarded to the Quality Assurance Process Improvement team monthly for review and recommendations, to include ensuring successful evaluation.	

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F 550	Continued From page 5 eating. E12 stated that her lunch had to be made special. 2/6/19 12:57 PM - R27 received peanut butter and jelly sandwich approximately a 1/2 hour after others at her table were being served and staff were already assisting the others to eat. The facility failed to serve all residents at one table their food at the same time. These findings were reviewed with E1 (NHA) and E2 (DON) at the exit conference on 2/12/19 beginning at 2:30 PM.	F 550		
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 by: Based on record review and interview, it was determined that for two (R6 and R27) out of 21 sampled residents for investigation, the facility failed to ensure the accuracy of the MDS assessments. Findings include: 1. The following was reviewed in R6's clinical record: 8/16/18 - Admission History and Physical documentation included a diagnosis of dementia without behaviors. No diagnosis of psychotic disorder was documented. 11/16/18 - Significant change MDS assessment documented psychotic disorder. 2/7/19 at approximately 2:00 PM - An interview	F 641	F641 #1 - Accuracy of Assessments A1. R6 currently reside in the facility. E7 was re-educated and the MDS section L has been modified. A2. R27 currently resides in the facility. E7 was re-educated and the MDS Section I has been modified. B1. An audit of residents care plan was completed and reviewed for broken dentures. No variances were noted. B2. An audit of residents who are currently receiving psychoactive medication was completed and reviewed to ensure that a proper diagnosis was coded on the MDS with supporting documentation reflecting the diagnosis in the clinical record.	3/29/19

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F 641	Continued From page 6 with E4 (RN) confirmed R6's clinical record did not include a diagnosis of psychotic disorder. 2/7/19 at approximately 3:00 PM - An interview with E7 (LNC) confirmed that the above MDS assessment was inaccurately coded as R6 having a diagnosis of psychotic disorder. 2. The following was reviewed in R27's clinical record: 6/25/18 - R27 was admitted to the facility. 9/25/18 - Dental consult for broken left front tooth of denture. 10/2/18 - The Quarterly MDS assessment was not coded for a broken denture. 1/2/19 - The Quarterly MDS assessment was not coded for a broken denture. 2/8/19 2:14 PM - An interview with E7 (LNC) it was stated that if the broken denture was not an issue nutritionally, chewing issues, or pain that area of the MDS would not be coded for the broken denture. 2/11/19 9:31 AM - During an interview with E1 (NHA) it was reported that he conversed with the corporate "over-seer of MDS" who reported that the dental section per his review of the RAI Manual did indicate that it should have been coded for the broken denture. E1 reported that E7 (LNC) was completing a modification of the two inaccurately coded assessments. The facility failed to code two MDS assessments to accurately reflect R27's broken denture.	F 641	C1. The Corporate Director of Health Informatics will re-educate the RNAC upon her return and LNAC regarding the accuracy of assessments and that the dental section of the MDS needs to reflect the broken denture. C2. The Corporate Director of Health Informatics will re-educate the RNAC upon her return and LNAC regarding the accuracy of assessments and that Section I of the MDS requires a proper diagnosis for an antipsychotic with supporting documentation in the clinical record. D1. An audit of 5 residents care plans with broken dentures will be reviewed by the Director of Nursing/designee monthly x3 months until 100% compliance to ensure accurate documentation on MDS section L. All audit results will be forwarded monthly to the Quality Assurance Process Improvement team for review and recommendations, to include ensuring successful evaluation. D2. An audit of 5 residents on psychoactive medications will be audited by the Director of Nursing/designee weekly X4 weeks until 100% compliance and then monthly X2 months until 100% compliance to ensure diagnoses are appropriate with supporting documentation in the clinical record and to ensure accurate coding on the MDS section I. All audit results will be forwarded monthly to the Quality Assurance Process Improvement team for review and recommendations, to include ensuring successful evaluation.	

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F 641	Continued From page 7 These findings were reviewed with E1 (NHA) and E2 (DON) at the exit conference on 2/12/19 beginning at 2:30 PM.	F 641		
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	F 656		3/29/19

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F 656	Continued From page 8 local contact agencies and/or other appropriate 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 observations, interviews and record review, it was determined that for one (R27) out of 21 sampled residents reviewed for investigation it was determined that the facility failed to review and revise R27's care plan to reflect her requests for soft foods (soup and soft sandwiches) for lunch and dinner related to a broken denture. Findings include: The following were reviewed in R27's clinical record: 6/25/18 - R27 was admitted to the facility. 7/2/18 - Physician's order for heart healthy with thin, liquids 1800 millimeter fluid restriction, lactose free milk, regular diet. 9/14/18 - R27's care plan included: the problem that stated R27 has a denture with a chipped tooth. The goal stated R27 will be able to chew food per recommendations at each meal thru next 90 days. Approaches included: 1. Dental consult as ordered 2. Monitor for changes in ability to chew diet and report to MD, SLP. 9/25/18 - Dental consult for broken dentures.	F 656	F656 Develop/Implement Comprehensive Care plan A. R27 currently resides in the facility and her care plan was updated to reflect her dietary preferences due to her broken dentures. No ill effects were experienced. B. An audit of current residents care plans was completed to determine if any residents had broken dentures and if so their care plans were updated to reflect their food preferences. C. Nursing staff, dietician and RNAC will be re-educated to ensure that residents with broken dentures will have their food preferences care planned and updated as needed. D. An audit of residents will be completed by the Director of Nursing/designee weekly x4 weeks until 100% compliance and then monthly for 2 months until 100% compliance to ensure that care plans are up to date and reflect resident food preferences due to broken dentures. All audit results will be forwarded monthly to the Quality Assurance Process Improvement team for review and recommendations, to include ensuring successful evaluation.	

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F 656	Continued From page 9 2/6/19 10:44 AM - An observation that R27 had a front tooth broken off of denture. 2/7/19 12:54 PM - An interview with R27 who reported to surveyor that s/he needs soft diet related to broken denture. "That is why I always order the soft sandwiches." 2/8/19 6:18 PM - "Progress note documented resident was noted at the dining room by this writer holding a piece of denture. Resident was asked what happened, resident stated my teeth fell out as I was eating my grilled cheese". 2/11/19 12:44 PM - During an interview with E9 (RD) when brought to the attention by the surveyor that R27 had been requesting throughout the survey to have soft foods soups and sandwiches and was ordering peanut butter and jelly and grilled cheese everyday, E9 stated that she was going to talk to her today regarding having soups and available that she desires. 2/12/19 12:14 PM Interview with E9 (RD) who reported that she did speak with the resident yesterday 2/11/18 and that is when she became aware of her preferences for soup and sandwiches and soft diet related to broken denture. E9 did say that s/he did down grade her diet to mechanical soft after the conversation with R27 yesterday and knowledge of another piece of denture breaking. (This surveyor was told prior to the second piece of denture breaking by resident that she already needed soft food.) The facility failed to review and revise R27's care plan to reflect requested food choices related to a broken denture. These findings were reviewed with E1(NHA) and	F 656		

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F 656	Continued From page 10 E2 (DON) at the exit conference on 2/12/19 beginning at 2:30 PM.	F 656		
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 determined that for one (R42) out of 21 residents sampled for investigations, the facility failed to ensure that care plans were developed by the IDT (Interdisciplinary team) which included a nurse aide with responsibility for the resident. Findings	F 657	F657 – Care Planning Timing and Revision A. R42 currently resides in the facility and will remain as a long term resident; the care plan was reviewed with resident's	3/29/19

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F 657	Continued From page 11 include: The facility policy entitled "Resident Assessment Care Planning" last updated 12/18/17 indicated the comprehensive care plan will have input from the following IDT team members; a. The attending physician. b. A registered nurses with responsibility for the resident. c. A nurse aide with responsibility for the resident. The following was reviewed in R42's clinical record: 1/23/19 - A Quarterly MDS assessment was completed for R42. 1/24/19 - The care plan meeting attendance sheet documented the following IDT members in attendance, a registered nurse, a hospice nurse, a physician representative, and the residents representative, there was no signature of a nurse aide in attendance. 2/12/19 at 9:00 AM - E7 (LPN) and licensed nurse coordinator confirmed a nurse aide was not in attendance for R42's care plan meeting. These findings were reviewed with E1 (NHA) and E2 (DON) at the exit conference on 2/12/19 beginning at 2:30 PM.	F 657	assigned certified aides and any changes voiced by the certified aides were incorporated into the plan of care and reviewed by the resident and /or representative. B. An audit of current resident care plan attendance was reviewed to determine the involvement of the certified aide with responsibility to the resident in order to develop the resident's plan of care. C. All nursing staff, RNAC, DON, and ADON will be re-educated on the care planning process and the required input of the certified aide responsible for the resident. D. An audit of residents who are scheduled for a care plan meeting will be reviewed by the Director of Nursing/designee weekly X4 weeks until 100% compliance and then monthly X2 months until 100% compliance to ensure a certified aide was in attendance. All audit results will be forwarded to the Quality Assurance Process Improvement team for review monthly and recommendations, to include ensuring successful evaluation.	
F 660 SS=D	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the	F 660		3/29/19

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F 660	Continued From page 12 reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who	F 660		

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F 660	Continued From page 13 made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R48) out of three residents sampled for discharge review, the facility failed to ensure that discharge planning process involved an IDT (interdisciplinary team) which included a nurse aide with responsibility for the resident, in the ongoing process of developing the discharge plan. Findings include: Review of R48's clinical record revealed the following; 1/14/19 - R48 was admitted to the facility.	F 660	F660 – Discharge Planning Process A. R48 currently resides in the community and will remain as a long term resident; her discharge care plan was reviewed and it was determined that she will remain as a long term care resident. B. An audit of current resident discharge plan attendance was reviewed to determine the involvement of the certified aide with responsibility to the resident in	

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F 660	Continued From page 14 2/4/19 - A noted documented "IDT care plan meeting held with resident and POA (power of attorney), clinical staff present .....therapy, transitional care unit manager, staff nurse, Assited Living (AL) apartments resident service director... discharge goal is for resident to return to AL apt....rehab will follow resident for outpatient rehab upon discharge no DME (durable medical equipment) needs anticipated at this time." 2/4/19 - The care plan meeting attendance sheet documented the following IDT members in attendance, a registered nurse, , a physician representative, and the resident, there was no signature of a nurse aide in attendance. During and interview on2/12/19 at 8:30 AM with E7 (LPN/LNC) it was confirmed a nurse aide was not in attendance for R48's care plan meeting. During an interview on 2/12/19 at 8:35 AM with E4 (RN) supervisor it was reported that typically a nurse aide attends care plan meetings including discharge meetings. During an interview on 2/12/19 at 8:50 AM with E1 (NHA) it was reported that "It is our practice that a nurse aide attends". These findings were reviewed with E1(NHA) and E2 (DON) at the exit conference on 2/12/19 beginning at 2:30 PM.	F 660	order to develop the resident's on going discharge plan of care. C. All nursing staff, RNAC, DON, and ADON will be re-educated on the discharge planning process and the required input of the certified aide responsible for the resident. D. An audit of residents who are scheduled for a discharge planning meeting will be reviewed by the Director of Nursing/designee weekly X4 weeks until 100% compliance and then monthly X2 months until 100% compliance to ensure a certified aide was in attendance. All audit results will be forwarded to the Quality Assurance Process Improvement team for review monthly and recommendations, to include ensuring successful evaluation.	
F 675 SS=D	Quality of Life CFR(s): 483.24 § 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the	F 675		3/29/19

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F 675	Continued From page 15 facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility failed to provide positioning support for dining for one (R32) out of randomly observed residents in the Long Term Care dining room. R32 was positioned inconsistent with the plan of care to maximize independence while eating and decrease pain. Findings include: 10/16/18 - Care plan - The following problems were documented: "R32 has self care deficits-needs extensive to total assist to complete ADL's. Related to arthritis... ". Approaches included: "Place items within reach." "Place resident at lower table, or use bedside table for eating meals (high tables too hard to feed herself due to pain)... Encourage her to feed as much as possible for self and staff to finish up and feed her rest of meals." 1/15/19 - MDS Quarterly - Documents R32 requires supervision oversight and encouragement or cueing with support for eating with one person physical assistance. 2/6/19 at 12:08 PM - R32 was observed in a wheel chair and placed at a table in the dining room approximately 16 inches from the table. 2/6/19 at 12:20 PM - R32 was observed being provided a beverage in a special cup and it was just out of reach when R32 tried to grab the cup.	F 675	F675- Quality of Life A. R32 currently resides in the facility and sustained no ill effects from improper positioning during the observed meal. B. A meal time audit was completed to ensure residents were positioned appropriately to promote independence with meal times. No other variances were noted. C. Staff Development will re-educate the nursing .and dining staff regarding appropriate positioning of residents in the dining room and food and drink placement on tables during meals to enable resident independence with eating. D. An audit at meal times will be completed by the Director of Nursing/designee weekly X4 weeks until 100% compliance and monthly X2 months to ensure that resident's positioning needs are utilized to maximize resident independence while in the dining room All audit results will be forwarded to the Quality Assurance Process Improvement team monthly for review and recommendations, to include ensuring successful evaluation.	

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F 675	Continued From page 16 2/6/19 at 12:30 PM - R32 was observed receiving her meal on a special plate, the cup was moved a little more to the left but still out of reach. R32 tried to reach for a spoon and was unable to reach the spoon. When another resident's meal was brought to the table, R32 said "I can't reach it" E12 (CNA) moved the wheelchair and the plate so that R32 was closer to the table. R32 tried to get her cup that was still out of reach and R32 used her spoon to try and to hook it to bring it within reach. During an interview on 2/6/18 at 12:33 PM R32 revealed that she has arthritis and has pain in both shoulders making it difficult to reach. 2/6/19 at 12:38 PM - R32 was observed waving to get E12's (CNA) attention. E12 returned and moved the beverage with in her reach. The facility failed to properly position R32's wheelchair, plate and cup for dining resulting in R32 not being able to feed herself for over 8 minutes. These findings were reviewed with E1(NHA) and E2 (DON) at the exit conference on 2/12/19 beginning at 2:30 PM.	F 675		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-	F 693		3/29/19

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F 693	Continued From page 17 §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of other facility documentation as indicated, it was determined that the facility failed to provide appropriate treatment and services for two (R15 and R49) out of two sampled residents who received feeding through a feeding tube (gastrostomy tube/GT). Additionally, the facility failed to have a written standard of practice for maintaining a GT. Findings include: "Auscultation verification of GT placement solely by auscultation, which involves instillation of air into the tube while simultaneously listening with a stethoscope over the epigastric region for the sound of air, is no longer recommended." (Emergency Nurses Association, Clinical Practice Guidelines: Gastric Tube Placement Verification, 2017). 1. Review of R15's clinical record review revealed: 2/1/19 to 3/1/19 - A physician's order indicated to check (feeding) tube placement prior to tube	F 693	F693 #2 –Enteral Feeding Management/Restore Eating Skills A. R49 –a new bottle of enteral feeding formula was labeled with resident name, room number, date and time at the time of the finding. R45 experienced no ill effects from undated enteral feeding. B. Audit of current residents receiving enteral feedings has been completed; enteral feeding bottles are labeled correctly. C. Licensed nursing staff has been re-educated on the process of labeling enteral feeding bottles with the proper information, which includes resident name, room number, date, and time. D. An audit of 3 residents receiving enteral feedings will be audited by the Director of Nursing / designee to ensure tube feeding bottle is labeled correctly with resident name, room number, date and time will be completed 5 times x1 week until 100% compliance, then weekly x4 until 100% compliance , and monthly	

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F 693	Continued From page 18 feeding and medications. 2/7/19 beginning at approximately 4:45 PM- E5 (LPN) was observed instilling approximately 60 cc of air, using a syringe, into R15's tube and auscultated the abdomen. E5 proceeded to fill the syringe with approximately 50 cc of water to flush the tube and verbalized, "there was no residual." The facility failed to check placement of a feeding tube by properly checking gastric residual volume. 2/7/19 at approximately 5:50 PM - During an interview with E2 (DON), surveyor inquired if the facility had a written procedure for checking placement of the feeding tube. E2 verbalized she will follow-up with the surveyor. 2/8/19 at approximately 11:00 AM - E11 (SE) provided the surveyor, a document titled Enteral Pump Feedings Through Enteral Feeding Tube. This document indicated "Verify placement of tube as appropriate for enteral feeding tube." Surveyor inquired if there was written procedure to verify placement and E11 verbalized that the facility did not have a written procedure. 2/12/19 at approximately 12:45 PM - E11 (SE) verbalized to surveyor that the facility will be implementing a competency skill checklist to ensure all staff are utilizing the correct technique in checking for placement of a feeding tube by checking the gastric residual volume. The facility failed to ensure feeding tube placement was checked in preparation to start tube feeding. In addition, the facility failed to have a written standard of practice for maintaining a feeding tube, including a procedure for checking placement of the tube.	F 693	x2. All audit results will be forwarded monthly to the Quality Assurance Process Improvement team for review and recommendations, to include ensuring successful evaluation. F693 #1 –Enteral Feeding Management/Restore Eating Skills A. R15 currently resides in the facility and no ill effects were noted from improper gastric residual technique. E5 was educated on the proper procedure to verify placement of a G-tube by checking for gastric residual volume. B. An audit of current residents receiving enteral feeding was completed by the Director of Nursing / designee to ensure proper technique is being used when checking for gastric residual volume. No ill effects were noted. C. Licensed Nursing Staff will be re-educated on the proper procedure to verify tube feed placement by properly checking for gastric residual volume with return demonstration on proper technique. D. Random audits of 3 Licensed Nursing staff will be completed by the Director of Nursing /designee daily covering all shifts, including weekends, for 4 weeks until 100% compliance and then monthly for 2 months until 100% compliance to ensure that each nurse performs proper technique when checking for gastric residuals volume. All audit results will be forwarded monthly to the Quality Assurance Process Improvement team for review and recommendations, to include ensuring successful evaluation.	

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F 693	Continued From page 19 2. The following were reviewed in R49's clinical record: 10/22/18 - R49 was admitted to the facility requiring a tube feeding related to a swallowing disorder. 11/4/18 - A physician's order for tube feeding for 18 hours daily. 2/6/19 9:39 AM - An observation of R49 with infusing tube feeding without date and time on label. 2/6/19 9:45 - An interview with E11 (SE) who confirmed that R49's tube feeding bottle was not labeled. S/he reported that it was the facility's standard of practice to date and time a tube feeding bottle at the time that the new bottle is initiated. The facility failed to follow the standard of practice for labeling a tube feeding bottle. These findings were reviewed with E1(NHA) and E2 (DON) at the exit conference on 2/12/19 beginning at 2:30 PM.	F 693		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by:	F 697		3/29/19

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F 697	Continued From page 20 Based on clinical record reviews, interviews, and review of facility policy as indicated, it was determined that for one (R47) out of one resident reviewed for pain, the facility failed to ensure a complete pain assessment was conducted to evaluate the pain level prior to an administration of a pain medication and/or the effectiveness of pain medication. Findings include: The pain management standards were approved by the American Geriatrics Society in April 2002 which included: appropriate assessment and management of pain; assessment in a way that facilitates regular reassessment and follow-up; same quantitative pain assessment scales should be used for initial and follow up assessment; set standards for monitoring and intervention; and collect data to monitor the effectiveness and appropriateness of pain management. The facility's Pain Management policy, with the most recent approved date of 2/16/18 documented that residents who are able to be interviewed, the numerical scale of 1-10 was to be utilized, as follows: Mild pain (1-4), Moderate pain (5-7), and Severe pain (8-10). The policy further indicated for PRN pain medication orders, this should indicate teh appropriate pain level for administration. In addition, for PRN medication administration, the location of the pain, pain level, and any non-pharmacological interventions attempted to be documented on the MAR. The policy did not address the use of pain scales and the need for consistent assessment using the same pain scale before and after administration of PRN pain medication. Review of R47's clinical record revealed the	F 697	F697 – Pain Management A. R47 currently resides in the facility. Resident's numeric pain scale for pre and post pain evaluation/assessment has been updated on iMAR to reflect consistent assessment of pre and post pain evaluation/assessment. No ill effects were noted. B. An audit of current residents was completed to ensure that as needed pain medication orders have the pain scale attachment to accurately determine a pre and post numeric pain scale assessment. C. Licensed nursing staff will be educated on documenting pre and post numeric pain scales for as needed pain medication. The education will also include the adding of the pain scale attachment to all as needed pain medication orders. D. A random audit for 10 residents will be completed by the Director of Nursing/Designee weekly for 4 weeks until 100% compliance and the monthly for 2 months until 100% compliance to determine that physician as needed pain medication orders have pain scales attached to the order, and that a pre and post numeric scale is documented. All audit results will be forwarded monthly to the Quality Assurance Process Improvement team for review and recommendations, to include ensuring successful evaluation.	

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following:

1/14/19 - Admission physician's order stated:

- Tramadol (pain reliever) 50 mg take one tablet every 12 hours PRN for moderate to severe pain.
- Acetaminophen (pain reliever) 500 mg, take two tablets every 6 hours PRN for mild pain.

1/14/19 - A care plan for chronic arthritic pain stated a goal that R47's pain will be decreased to tolerable level or eliminated within the next 90 days and the tolerable pain was 5. Interventions included to to assess location and duration of pain and any contributing factors, administer pain medication as ordered and to assess effectiveness, and to complete pain assessment on admission, quarterly and as needed when intensity/location of pain changes.

1/14/19 through 1/31/19 - R47's MAR revealed that 10 doses of as needed Acetominophen were signed off as administered. Of the 10 doses, only on 2 occasions was a pre and post numeric pain scale utilized. The remaining 8 doses did not document either a pre medication numeric pain score and/or the post administration numeric pain score. No Tramadol was administered during this period of time.

2/1/19 through 2/5/19 - R47's MAR revealed the following:
- Acetominophen were signed off as administered on 9 occasions. Of the 9 doses, only on 2 occasions was a pre and post numeric pain scale utilized. For the remaining 7 doses, the facility did not document either a pre medication numeric pain score and/or the post administration numeric pain score.

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F 697	Continued From page 22 - Tramadol were signed off as administered on 4 occasions. Of the 4 doses, 1 dose did not document the post administration pain score. These findings were reviewed with E1(NHA) and E2 (DON) at the exit conference on 2/12/19 beginning at 2:30 PM.	F 697		
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 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;	F 880		3/29/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085032	A. BUILDING _____ B. WING _____	C 02/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMINSTER VILLAGE HEALTH	1175 MCKEE ROAD DOVER, DE 19904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 23 (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 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 observation, interview, and review of other facility documentation, it was determined, that the facility failed ensure proper cleaning and disinfecton of a glucometer was performed during one out of ten medication administration	F 880	F880 – Infection Prevention & Control A. E4 and E8 were educated on proper glucometer cleaning and disinfection between uses.	

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F 880	Continued From page 24 observation. Findings include: 2/7/19 at approximately 4:21 PM - During medication pass observation, E8 (RN) used an alcohol pad to clean the glucometer before and after performing FSBS testing. 2/7/19 at approximately 4:29 PM - During an interview, E4 (RN) was asked how the facility cleaned and disinfected the glucometer in between resident use. E4 verbalized that a bleach wipe would be utilized. 2/7/19 at approximately 4:50 PM - During an interview with E2 (DON). the surveyor asked how the facility cleaned and disinfected the glucometer between resident use. E2 provided the surveyor, the facility's policy and procedure titled, Glucometer Testing policy, with the most recent revision date of 2/18/15, which indicated the glucometer would be cleaned using an EPA approved disinfectant or 1 to 10 ratio bleach to water solution. E2 confirmed that an alcohol pad would not be used to clean and disinfect a glucometer. These findings were reviewed with E1(NHA) and E2 (DON) at the exit conference on 2/12/19 beginning at 2:30 PM.	F 880	B. An audit of current residents who require glucometers readings was completed to ensure proper cleaning technique is being used for glucometer cleaning and disinfection. No ill effects noted. C. Licensed Nursing staff were re-educated on the proper cleaning and disinfection of glucometers and will provide a return demonstration of proper technique. D. A random audit of 5 nurses will be completed weekly by the DON/designee for 4 weeks until 100% compliance and then monthly for 2 months until 100% compliance to ensure that each nurse performs proper technique for the cleaning and disinfection of glucometers during medication administration. All audit results will be forwarded monthly to the Quality Assurance Process Improvement team for review and recommendations, to include ensuring successful evaluation.	
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;	F 883		3/29/19

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F 883	Continued From page 25 (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and	F 883		

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F 883	Continued From page 26 (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to ensure for one (R46) out of five sampled residents for immunization review that the resident or the resident representative was offered and had the opportunity to refuse or receive influenza and/or pneumonia vaccinations. Findings include: The facility policy entitled "Immunizations" last updated 2/27/18 indicated the following: - Before offering influenza/pneumococcal immunization, each resident or the residents legal representative receives education regarding the benefits and potential side effects of the immunization. -Each resident is offered annual influenza/pneumococcal immunization October 1 through March 31 annually. Review of R46's clinical record revealed: 10/20/18 - R46 was admitted to the facility from the attached assisted living facility. 2/12/19 at 11:15 AM - E2 (DON) provided the surveyor with R46's immunization record which documented R46's most recent influenza vaccination as 10/5/17 and most recent pneumonia vaccination as 10/28/93. During an interview on 2/12/19 at 11:55 AM E2 (DON) confirmed that R46 was not offered nor provided education or vaccination influenza and/or pneumonia. During the same interview, E2	F 883	F883 – Influenza and Pneumococcal Immunizations A. R46 currently resides in the facility and the POA was offered and provided education for the influenza vaccine and pneumococcal vaccine. Resident has received both the influenza and pneumococcal vaccine. B. An audit of current residents was completed to determine that the resident or their representative was offered and had the opportunity to refuse or receive the influenza and pneumococcal vaccines. Any resident lacking support that they received vaccinations or refused the opportunity to be vaccinated will be offered C. Licensed nursing staff was re-educated to offer all new admissions and /or their representatives the influenza and pneumococcal vaccines. D. All Admissions will be reviewed weekly for 4 weeks by the Director of Nursing/designee until 100% compliance then monthly for 2 months until 100% compliance to ensure that the influenza / pneumococcal vaccinations are reviewed upon admission and offered as indicated. All audit results will be forwarded to the Quality Assurance Process Improvement	

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F 883	Continued From page 27 also confirmed that the facility was not aware of the resident's immunization status until brought to the attention by the surveyor during immunization review. These findings were reviewed with E1 (NHA) and E2 (DON) at the exit conference on 2/12/19 beginning at 2:30 PM.	F 883	team monthly for review and recommendations, to include ensuring successful evaluation.	

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

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3 Mill Road, Suite 308
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STATE SURVEY REPORT

NAME OF FACILITY: Westminster Village Health Center DATE SURVEY COMPLETED: February 12, 2019

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTIONOF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced annual and complaint survey was conducted at this facility from February 6, 2019 through February 12, 2019. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and other facility documentation as indicated. The facility census the first day of the survey was 59. The survey sample totaled thirty-three (33). Abbreviations/Definitions used in this report are as follows: BOM – Business Office Manager; DON – Director of Nursing; NHA - Nursing Home Administrator; COTA/L – Certified Occupational Therapy Assistant/Licensed.		
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.** **This requirement is not met as evidenced by:** Cross Refer to the CMS 2567-L survey completed February 12, 2019: F550, F641, F656, F657, F660, F675, F693, F697, F880, and F883.	Cross Reference plan of correction for CMS 2657-L survey F550, F641, F656, F657, F660, F675, F693, F697, F880, and F883.	3/29/19
3225.9.5	**Requirements for tuberculosis and immunizations:**		
3225.9.5.2	**9.5.2 Minimum requirements for pre-employment require all employees to have**		

Provider's Signature [signature] NHA Title Administrator Date 3/29/19

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SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTIONOF DEFICIENCIES	COMPLETION DATE
	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. Based on review 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 one (E13) out of 14 sampled employees. Findings include: Review of the facility's documentation titled, Tuberculin Testing Policy, with a revision date of 2/27/18 stated, a 2 step TB testing was required upon hire. E13 (COTA/L) hire date was 12/7/18 and E13's first day in the facility was 12/8/18. There was a lack of evidence of a 2 step TB testing. 2/12/19 at approximately 12:45 PM – An interview with E8 (BOM) confirmed that the facility failed to complete the 2 step TB testing. 2/12/19 beginning at 2:20 PM - Findings were reviewed with E1 (NHA), and E2 (DON) during the exit conference.	3225.9.5 3225.9.5.2 1. No Resident was affected by this citation; while potentially all residents could be affected. 2. A review of employee files for new hires in the past 30 days to verify that a two-step TB test was completed upon hire. 3. All facility staff will be monitored by Human Resources to verify receipt of a pre-employment two-step TB Test. Therapy contracted staff will have new hire information submitted to the Administrator/designee for review and ap[proval prior to their starting in the facility.	3/29/19

Provider's Signature Ly Hellyer NHA Title Administrator Date 3/24/19

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STATE SURVEY REPORT

NAME OF FACILITY: Westminster Village Health Center DATE SURVEY COMPLETED: February 12, 2019

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTIONOF DEFICIENCIES	COMPLETION DATE
		4. The Administrator/designee will audit all new hires for the next 30 days or until 100% compliance is achieved to verify the new employee has received a two-step TB test prior to working with residents. The results of the audits will be presented to the QAPI Team monthly for further recommendations.	3/29/19

Provider's Signature [signature] NHA Title Administrator Date 3/24/19