

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>085010</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/15/2018</b>
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NAME OF PROVIDER OR SUPPLIER  <b>MILFORD CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>700 MARVEL ROAD</b> <b>MILFORD, DE 19963</b>
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E 000	Initial Comments  An unannounced annual and complaint survey was conducted at this facility from May 31, 2018 through June 15, 2018. The facility census the first day of the survey was 125 (one hundred twenty five). An emergency preparedness survey was also conducted during the same time period. There were no emergency preparedness deficiencies based on observation and interviews.	E 000		
F 000	INITIAL COMMENTS  An unannounced complaint and annual survey was conducted at this facility from May 31, 2018 through June 15, 2018. The deficiencies contained in this report are based on observation, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 125. The survey sample totaled fifty three (53).  Abbreviations/Definitions used in this report are as follows: NHA - Nursing Home Administrator; DON - Director of Nursing; ADON - Assistant Director of Nursing; AD-Activity Director; RN - Registered Nurse; LCSW - Licensed Clinical Social Worker LPN - Licensed Practical Nurse; UM - Unit Manager; MD - Medical Doctor; RNAC - Registered Nurse Assessment Coordinator; CNA - Certified Nurse's Aide; FSD - Food Service Director; RD - Registered Dietitian;	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <b>Electronically Signed</b>	TITLE	(X6) DATE <b>07/08/2018</b>
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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	<p>Continued From page 1</p> <p>NP - Nurse Practitioner; PA - Physician Assistant; PT - Physical Therapist; FMD-Facility Maintenance Director; SW - Social Worker; CRN - Corporate RN;</p> <p>ADLs - Activities of Daily Living, such as bathing and dressing; ADL Self-Performance Extensive Assistance - resident involved in activity, staff provide weight-bearing support; Limited Assistance - resident highly involved in activity, staff provide guided movement of limbs or other non-weight bearing assistance; Supervision - oversight, encouragement or cueing; Total Dependence - full staff performance every time activity performed; Alzheimer's Disease - brain disorder causing loss of memory, thinking and language; Anxiety - intense, excessive and persistent worry or fear about everyday situations; Antipsychotic - drug to treat psychosis and other mental/emotional conditions; AIMS (Abnormal Involuntary Movement Scale) - test to measure body movements the resident cannot control, side effects of antipsychotic medications; BID - two times daily; BIMS (Brief Interview for Mental Status) - test to measure thinking ability with score ranges from 00 to 15. 13-15 Cognitively Intact 8-12 Moderately Impaired 0-7 Severe Impairment Braden/Norton Scale - skin risk assessment to determine risk for developing a pressure ulcer; Care Area Summary (CAA) - part of the MDS</p>	F 000		
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F 000	Continued From page 2 assessment to identify and plan for problem areas; CDC - Centers for Disease Control and Prevention; cm (centimeter) - metric measurement of length; Cognitive function - mental abilities; Cognitively intact - able to make own decisions; Communicable Disease - disease that is spread from one person to another; Contenance - control of bladder and bowel function; D - depth of a wound; Delirious / Delirium - brief state of excitement and mental confusion; Delusion - false belief that is thought to be true; Dementia - loss of mental functions such as memory and reasoning that is severe enough to interfere with a person's daily functioning; Depression - mood disorder with feelings of sadness; Dermatitis - irritation of the skin; Dysphagia - difficulty swallowing; Dialysis - cleansing of the blood by artificial means when kidneys have failed; e.g. - abbreviation that means "for example;" i.e. - abbreviation used to give more information about something that was just mentioned; etc. - abbreviation for the Latin word et criteria - which means "and so on;" EMR - Electronic Medical Record; Epithelial - new skin cells that are a different color [usually white or pink] from surrounding area; ER - Emergency Room; Eschar-dead brown, black tissue; F (Fahrenheit) - measurement of temperature; FMP (Facility Maintenance Program) - scheduled tasks, like walking, to maintain function; Foley catheter - indwelling urinary catheter to drain urine from bladder;	F 000		

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F 000	Continued From page 3 Germicidal - a substance that kills germs/bacteria; Glucometer - medical device that reads blood sugar levels; Gluteal Cleft - indentation between buttocks; Granulation - new tissue with blood vessels formed during wound healing; H - height of a wound; Hallucinations - something that seems real but does not really exist; Hallux - big toe; HS - hour of sleep; Incontinence - loss of control of bladder and bowel function; Always incontinent - no episodes of continence; Frequently incontinent - 7 or more episodes of incontinence, but at least one episode of continent voiding during a 7 day period; Occasionally incontinent - less than 7 episodes of incontinence; Intravenous (IV) - administration of medications/fluids through a tube directly into a vein; L-length; LTC-long term care; Magnetic Resonance Imaging (MRI) -an imaging technique to take pictures inside the body; MAR - Medication Administration Record; MASD (Moisture Associated Skin Damage) - incontinence associated skin irritation MDS (Minimum Data Set) - standardized assessment used in nursing homes; Medication Regimen Review (MRR) - monthly review of resident's medications, laboratory tests etc. by a pharmacist to see if anything unusual exist; Mid Level Provider - nurse practitioner or physician assistant; mL (milliliters) - measurement of liquid 5 ml = 1	F 000			

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F 000	<p>Continued From page 4</p> <p>teaspoon</p> <p>mg (milligrams) - measurement of weight;</p> <p>Moderate Cognitive Impairment - decisions poor, cues / supervision required;</p> <p>Myocardial Infarction (MI) - heart attack;</p> <p>Necrosis / Necrotic - tissue death, usually due to interruption of blood supply or injury;</p> <p>Neurologia - pain caused by nerve irritation;</p> <p>Nutritional supplement - high calorie liquid drink;</p> <p>Pain Scale - rating pain severity on a 0 to 10 scale with 0 meaning no pain and 10 meaning the worst pain;</p> <p>Paranoia - extreme fear of perceived danger;</p> <p>Parkinsons disease - brain disorder affecting movement leading to shaking/tremors and difficulty walking;</p> <p>PAS Unit (Preadmission Screening Unit) - Screening unit to identify persons with possible mental illness or mental retardation or related conditions who are applying to, or residing in, nursing facilities;</p> <p>Perineal care - cleansing of area between the thighs, external genitals and anus;</p> <p>POS (Physician Order Sheet) - monthly list of current physician orders;</p> <p>Pre - before;</p> <p>Post - after;</p> <p>PASARR (Pre-Admission Screening and Annual Resident Review) - evaluation performed for determination of mental illness and recommendations;</p> <p>lbs (pounds) - abbreviation for weight;</p> <p>% - percentage;</p> <p>Peripherally Inserted Central Catheter (PICC) - special catheter in the vein that can be used for a longer period of time;</p> <p>PPD - a skin test used as a tool to screen for TB;</p> <p>PRN - when necessary;</p> <p>Pressure ulcer -PU- sore area of skin that</p>	F 000		
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F 000	<p>Continued From page 5</p> <p>develops when blood supply to it is cut off due to pressure of laying / sitting on it, measured in stages;</p> <p>Stage I - intact red skin ;</p> <p>Stage II - blister or shallow open sore with red/pink color;</p> <p>Stage III - open sore that goes into the tissue under the skin;</p> <p>Stage IV - open sore so deep that muscle, tendon, or bone can be seen / felt.</p> <p>Unstageable - actual depth cannot be determined due to the presence of soft dead tissue and or hard dead tissue;</p> <p>Deep Tissue Injury (DTI) - purple or maroon intact skin or blood filled blister;</p> <p>Psychosis - loss of contact/touch with reality;</p> <p>Psychosocial - mental and emotional health;</p> <p>Psychotic - loss of contact ability to think rationally;</p> <p>Psychotropic - medication capable of affecting the mind, emotion, and behavior;</p> <p>Q - every;</p> <p>qd - every day (daily);</p> <p>RAI - Resident Assessment Instrument;</p> <p>Schizophrenia - a mental disorder with false beliefs, confused thinking and bizarre thoughts;</p> <p>Severe Cognitive Impairment - unable to make own decisions;</p> <p>Slough - yellow, tan, gray, green or brown dead tissue;</p> <p>Stroke - reduced blood supply or bleeding in the brain;</p> <p>Skin Prep - liquid dressing for intact skin to form protective film;</p> <p>TID - three times a day;</p> <p>TB - tuberculosis (lung infection caused by a bacteria);</p> <p>TCU-transitional care unit;</p> <p>Tunneling - channels extending from a wound</p>	F 000		
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F 000	Continued From page 6 into surrounding tissue; Undermining - skin edges have lost contact with underlying tissue; W - width of a wound; Wound VAC - negative pressure dressing to promote wound healing.	F 000		
F 550 SS=D	<p>Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2)</p> <p>§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.</p> <p>§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.</p> <p>§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.</p> <p>§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.</p> <p>§483.10(b)(1) The facility must ensure that the</p>	F 550		7/31/18

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F 550	<p>Continued From page 7</p> <p>resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.</p> <p>§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.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and interview it was determined that the facility failed to provide care and services in a manner that promoted dignity for one (1) (R49) out of 53 residents and for observations of during meal service. Findings include:</p> <ol style="list-style-type: none"> <li>1. During dinner meal observation on 6/9/18, at approximately 5:45 PM, E24 (CNA) referred to R49 as a "Feeder."</li> <li>2. During dinner meal observation on 6/9/18, at approximately 5:52 PM, E25 (CNA) verbalized "only feeders (dinner trays)" remained in the meal delivery cart.</li> <li>3. Meal observations on Homestead unit found brown paper towels were used as napkins. <ul style="list-style-type: none"> <li>- 6/4/18 (11:30 AM - 12:30 PM) lunch.</li> <li>- 6/8/18 (9:00 AM - 9:45 AM) breakfast.</li> <li>- 6/8/18 (11:30 AM - 12:50 PM) lunch.</li> </ul> </li> </ol> <p>During an interview with E31 (FSD) on 6/15/18 at 10:05 AM to review the use of brown paper towels during meal service on the Homestead unit, E31 stated the unit had cloth napkins and tablecloths and was not sure why they were not used. E31 indicated that s/he had taken the white</p>	F 550	<ol style="list-style-type: none"> <li>1. Staff received immediate communication in regards to resident dignity and use of napkins. Residents are no longer being referred to as "feeders". Napkins are being provided with each meal served.</li> <li>2. Any resident could be affected.</li> <li>3. Root Cause: Lack of communication and supervision of staff during meal delivery service between nursing and Food and Nutrition. Napkins will be provided with each meal tray delivery. Center Department Heads will educate nursing staff on or before 7/31/2018 on promotion of dignity and respect utilizing federal regulation 483.10(a)(1) under tag F550. New Process: Food service director will educate dietary staff on the new process for delivering napkins with each food cart to the Memory Care unit.</li> <li>4. Center will perform dining observations for napkin use and resident dignity during meals daily for 2 weeks, then weekly observations for 4 weeks until 100%</li> </ol>	



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F 550	Continued From page 8 paper napkins out in the past and saw someone using them to clean a spill off the floor.  Findings reviewed on 6/15/18, at approximately 11:30 AM with E1 (NHA), E2 (DON), and E40 (CRN).	F 550	compliance is obtained. Center will perform random audits monthly for 3 months to continue to observe compliance until 100% compliance is obtained. A summary of documented observations will be submitted to the QAPI committee monthly for 3 months for further recommendations and evaluation to sustain 100% compliance.		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7)  §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group.	F 565		7/31/18	

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F 565	<p>Continued From page 9</p> <p>§483.10(f)(6) The resident has a right to participate in family groups.</p> <p>§483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and review of resident council meeting minutes, it was determined that the facility failed to ensure that resident grievances were acted upon promptly and demonstrated their response and rationale for such response. Findings include:</p> <p>1. Staffing issues: Cross Refer F725.</p> <p>Review of the past 6 months of Resident Council Meeting minutes (12/6/17, 1/3/18, 2/7/18, 3/7/18, 4/11/18, 5/10/18 and 6/4/18) revealed staffing concerns were discussed at every meeting: multiple residents stated they had lengthy waits from the time they ring their call bell until their call bell was answered; short staffed on 11 PM -7 AM shift; CNAs do not stay; and agency nurses do not know residents. Facility's response to these monthly Resident Council complaints had either been that they were hiring new staff or there was no response recorded in the minutes.</p> <p>6/8/18 12:45 PM - 2:00 PM - Resident meeting with the surveyor, ombudsman and seven residents revealed the following issues: - Multiple residents stated that the facility does not consider the views of the resident / family groups nor does the facility act promptly upon grievances and / or recommendations.</p>	F 565	<p>1. R120, R27, R83, R25, R109, R95 grievances for missing clothes has been documented and investigated, to include center response. Dining room closure incident and grievance has been responded to by the CED to the resident council.</p> <p>2. Current residents had the potential to be affected.</p> <p>3. Root Cause: The Activity Director vacancy. New Center Activity Director has been educated to regulation of 483.10(f)5)(i)-(iv)(6)(7), and Center Grievance policy #OPS202 Grievance/Concern. The center director will educate activity staff on or before July 31, 2018 of the center Grievance policy and regulation relating to F Tag 565. New Process: The Activity Director or designee will transfer concerns presented at each resident council to a grievance form for further investigation and center response and document the center actions and response in the resident council minutes.</p> <p>4. Center Executive Director (CED) will</p>		

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F 565	<p>Continued From page 10</p> <ul style="list-style-type: none"> <li>- Multiple residents said that staff do not respond to the call light timely.</li> <li>- Residents confirmed that staffing concerns had been brought up at numerous Resident Council meetings over the past 9 months and facility administration continually responded that they were trying to hire new staff.</li> </ul> <p>The facility failed to act upon staffing grievances from the resident group in a timely manner.</p> <p>2. Laundry issues:</p> <p>September, 2017 - June, 2018 - Review of past 10 months of Resident Council Meeting minutes revealed laundry concerns were discussed at 8 of the monthly meetings:</p> <p>9/8/17- R120 and R27 had multiple items of personal clothing lost in laundry. -Facility's response: none.</p> <p>10/25/17 - R27 and R83 with multiple items of personal clothing lost in laundry. -Facility's response: none.</p> <p>11/1/17- R25 had multiple items of personal clothing lost in laundry. -Facility's response: none.</p> <p>12/6/17 - R109 with missing clothing in laundry. Residents want white markers available for labeling dark clothing. -Facility's response: none.</p> <p>1/3/18 - Resident want white markers for dark clothing. Laundry can put labels on clothing. - Complaints: Residents still would like white markers for making their dark clothes.</p>	F 565	<p>request that department heads be invited to resident council monthly from the resident council president to facilitate timely center response to concerns. The CED and Activity Director will meet monthly to review resident council minutes to include follow up documentation on resident concerns and will continue to meet until 100% compliance is obtained. The Activity Director will report findings to the QAPI committee for further recommendations and evaluation.</p>		

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F 565	Continued From page 11  2/7/18 - White pens have been ordered for labeling dark clothing. Discussion about a few missing items from laundry. - Facility's response: Listed R95's 4 missing items, but no facility response noted. White pens arrived and laundry staff can obtain them from the facility receptionist.  3/7/18 - Resident's state there was still missing personal laundry / clothes and their clothes "come back dingy." -Facility's response: none.  6/4/18 - Holes in towels. Residents received laundry with other resident name on it. -Facility's response: E32 (Housekeeping Supervisor) wrote that she asked laundry person not to put towels with holes on the cart. Receiving clothing belonging to other residents was not addressed.  6/8/18 12:45 PM - 2:00 PM - Resident meeting with the surveyor, ombudsman and seven residents revealed: - A[anonymous]1, A2 and A4 have lost personal clothing items in past year. - Staff may say they will look for the lost clothing, but "that is only giving us lip service." - There is a bin of lost & found in the laundry room, but residents "are not allowed to look in it. We have to tell staff and they are supposed to look for it." - Laundry gives out towels and sheets with holes.  6/13/18 at approximately 2:06 PM - An interview with E34 (Activity Director) revealed that s/he employment began on 4/30/18 and could not provide additional information from prior	F 565			

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F 565	<p>Continued From page 12</p> <p>grievances, but would be following up on future Resident Council grievances.</p> <p>6/14/18 at approximately 10:00 AM - An interview with E32 (Housekeeping Supervisor) and E7 (SW) revealed that previously complaints of missing personal items in the laundry had not been documented, but the facility will begin to document missing clothing on the "Concern/Grievance Form" which would be utilized to document and track missing clothing. When asked to respond to the missing laundry issues in the Resident Council minutes from the past 8 months, E32 stated if his/her response was not in the minutes s/he was not notified of the complaints.</p> <p>6/15/18 at approximately 11:30 AM - Interview: E1 [NHA] stated that facility was without an Activity Director for several months, but E34 is now following up on Resident Council grievances.</p> <p>The facility failed to act upon grievances about lost laundry from the resident group in a timely manner.</p> <p>3. During an interview with E32 (Housekeeping Supervisor), on 6/6/18 at approximately 11:00 AM, surveyor inquired if E32 was aware of R43's missing clothing, including jeans and a sweater. E32 recalled, that R43 had verbalized missing jeans shortly after R43's admission in March 2018, however, E32 related that currently, the facility had no system to document missing clothing. Shortly after this conversation, E32 provided a blank copy of a "Concern/Grievance Form" which will be utilized immediately to document and track missing clothing.</p> <p>There was lack of evidence that R43's concerns</p>	F 565			

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F 565	Continued From page 13 of her missing clothing was addressed.  4. Review of Resident Council Minutes for May and June 2018 revealed that the residents expressed grievances about the dining room being closed on weekends. E31 (Dietary Director) was present during the May 2018 meeting which was held on 5/10/18 and "...discussed residents concerns." Review of the "Departmental Response Form" dated 5/11/18 and signed by E1 (NHA), lacked evidence, regarding the facility's response to the above grievance.  An interview with E31 on 6/12/18, at approximately 5:00 PM confirmed that the main dining room had been closed due to food and nutrition staffing shortage within the past couple of months and this grievance was voiced during a recent Resident Council Meeting. E31 was asked by the surveyor for the facility's evidence of promptly acting upon the grievance and response to the Resident Council Committee. No further information was provided to the surveyor during the survey.  Findings were reviewed on 6/15/18, at approximately 11:30 AM with E1 (NHA), E2 (DON), and E40 (CRN).	F 565			
F 575 SS=D	Required Postings CFR(s): 483.10(g)(5)(i)(ii)  §483.10(g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives: (i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State	F 575		7/31/18	

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F 575	<p>Continued From page 14</p> <p>Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and (ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and interview, it was determined that the facility failed to post the telephone numbers of the Division of Health Care Quality's (DHCQ) abuse reporting hotline number in a form and manner accessible and understandable to residents and resident representatives. Findings include:</p> <p>6/14/18 (11:15 AM) - Observations of the facility lobby, hallways, resident units and common areas revealed that the DHCQ's abuse reporting hotline number was only posted next to the employee time clock.</p> <p>6/15/18 at approximately 11:00 AM - Interview with E1 (NHA) stated s/he thought this information was posted in the vestibule of the main facility entrance. Observation of the vestibule with E1 confirmed all required information was posted except for abuse</p>	F 575	<ol style="list-style-type: none"> <li>1. The DHCQ's posting has been moved to a central location.</li> <li>2. Any resident, representative, and/or visitor could be affected.</li> <li>3. Office staff have been informed of the required postings to assist with maintaining 100% compliance.</li> <li>3. CED will perform routine observations monthly to obtain 100% compliance.</li> <li>4. Office staff and CED will observe required postings weekly for 4 weeks, then monthly for 3 months. Observations will be documented on a new posting log for the next 3 months to obtain 100% compliance.</li> </ol>	

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F 575	Continued From page 15 reporting.	F 575			
F 580 SS=D	Findings reviewed on 6/15/18, at approximately 11:30 AM with E1, E2 (DON), and E40 (CRN) during the exit conference. Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15)  §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g) (14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or	F 580		7/31/18	



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F 580	<p>Continued From page 16</p> <p>(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.</p> <p>(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).</p> <p>§483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interviews, and review of other facility documentation, it was determined that the facility failed to consult with the attending physician or immediately inform a resident's representative of change of condition for two (R33 and R28) out of 5 residents in the sample with a facility acquired pressure ulcer. Findings include:</p> <p>Facility policy titled, Notification of Change in Condition, with an effective date of 11/28/16, stated that the facility must immediately...consult with the patient's physician...where there is:</p> <ul style="list-style-type: none"> <li>- A significant change in the patient's physical, mental, or psychosocial status (that is, a deterioration in health, mental or psychosocial status in either life-threatening conditions or clinical complications);</li> <li>- A need to alter treatment significantly (that is, a</li> </ul>	F 580	<ol style="list-style-type: none"> <li>1. R33 and R28 and/or their representatives and physician have been made aware of residents change in condition. Residents' physician orders reflect the physician's current recommendations for residents care.</li> <li>2. Residents with a change in condition (CIC), including skin concerns could potentially be affected. Current residents medical records have been reviewed from 6/15/18 to current to determine appropriate notifications were completed for CIC.</li> <li>3. Root Cause: Center staff lacked attention to detail. Center nurse leadership to include the Center Nurse Executive (CED) and Unit Managers, will review daily order changes and review</li> </ol>	

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F 580	<p>Continued From page 17</p> <p>need to discontinue or change an existing form of treatment due to adverse consequences, or to commence a new form of treatment)..."</p> <p>Facility policy and procedure titled, Skin Integrity Care Delivery Process, dated 6/1/16, documented the following under the section entitled Skin Integrity Impairment Identified: Indicated when a new skin impairment is identified, specific actions will be taken, including a discussion with the physician / mid level provider to obtain and document the probable wound type, wound outcome, and to obtain any needed orders. In addition, a discussion with patient / family to provide education related to type of wound and anticipated / probable outcome (as per the provider).</p> <p>1. Cross refer F686, Example #1. Review of R33's clinical records revealed:</p> <p>5/24/18 and timed 3:00 PM - Nursing Note, by E27 (LPN), documented a new skin impairment, a PU, of the right hallux [big toe] 1.0 cm x 1.0 cm with redness surrounding area.</p> <p>5/24/18 and timed 10:36 PM - Nursing Note, by E27, documented a change in condition and the managed care organization was notified at 12 midnight on 5/25/18.</p> <p>5/24/18 - Skin Integrity Report (SIR), by E27, documented a new, in-house acquired unstageable PU of the right hallux. Appearance was intact deep purple, 1.0 cm L x 1.0 cm W x no depth.</p> <p>Although the facility had identified this new skin impairment, record review lacked evidence of the</p>	F 580	<p>documentation/ progress notes for evidence of responsible party and MD/NP notification. The center will identify any additional root cause and adjust interventions as necessary.</p> <p>4. The center's CNE/ADON/UM's will randomly review 10% of census to determine responsible party and MD/NP notification of physician order changes daily until three consecutive reviews achieve 100% accuracy, then 3 times per week until 3 reviews achieve 100% accuracy, then weekly until 3 consecutive reviews achieve 100% accuracy, then monthly for three months until 3 reviews achieve 100% compliance. The CNE will report results to the QAPI committee monthly and the committee will provide further recommendations for sustainability of the plan. If 100% compliance is maintained, the issue will be removed from QAPI.</p>		

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F 580	<p>Continued From page 18</p> <p>facility of notification to/or a consultation with the attending physician. Additionally, record review lacked evidence of immediate notification of R33's power of attorney, R33's daughter.</p> <p>6/7/18 at approximately 11:00 AM - An interview with E2 (DON) confirmed the facility failed to have evidence of an immediate notification of the resident's daughter. It is unclear if R33's attending physician was consulted upon identification of the new skin impairment on 5/24/18 and additional evidence was requested during the survey, however, no additional evidence was provided.</p> <p>2. Cross refer F686, Example #2. Review of R28's clinical records revealed:</p> <p>6/3/18 - Skin Integrity Report documented a new skin impairment, as documented as a Stage II PU of the gluteal cleft with epithelial appearance, 0.5 cm L x 0.5 cm W x 1.4 cm D with no undermining / tunneling and with bloody drainage, no odor, healthy surrounding wound edges and tissue.</p> <p>Although the facility had identified this new skin impairment, record review lacked evidence of a consultation with the attending physician. In addition, Additionally, record review lacked evidence of immediate notification of R28's legal guardian, resident's mother.</p> <p>6/7/18 at approximately 11:30 AM - An interview with E2 (DON) confirmed the facility failed to have evidence of an immediate notification of the resident's mother. In addition, no further evidence was provided regarding physician consultation.</p>	F 580			

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F 580	Continued From page 19 Findings reviewed on 6/15/18, at approximately 11:30 AM with E1 (NHA), E2 (DON), and E40 (CRN).	F 580			
F 584 SS=B	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7)  §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.  The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.  §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;  §483.10(i)(3) Clean bed and bath linens that are in good condition;  §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);  §483.10(i)(5) Adequate and comfortable lighting levels in all areas;	F 584		7/31/18	

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F 584	<p>Continued From page 20</p> <p>§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and</p> <p>§483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility failed to ensure the interior was maintained in a sanitary, orderly and comfortable manner. The upholstered furniture on one (Homestead unit) out of 3 nursing units was dirty and stained and lacked a routine cleaning schedule. Findings include:</p> <p>1. 6/4/18 - 6/8/18 - Observation of dining chairs, lounge chairs/sofas on the Homestead (Memory Support) unit revealed dirty and stained seating in the lounge, activity/dining rooms and area by nursing station. 29 out of 30 seating pieces of upholstered furniture were stained and/or had dirty arm rests (21 out of 22 armed dining chairs, 4 out of 4 sofas, 5 out of 5 lounge chairs, 5 out of 5 upright chairs in front of television). One sofa had even been turned around facing backwards to prevent use on 6/5/18 - 6/8/18, due to an incontinence episode by a resident.</p> <p>During an interview with E61 (Housekeeper) on 6/8/18 at 11:40 AM, confirmed that the furniture was stained and dirty and did not get regular cleaning since the unit had to wait for them [staff who usually clean the floors] to get time to clean the furniture.</p>	F 584	<p>1. Upholstered furniture in the Memory Support Unit has been cleaned and is in good condition.</p> <p>2. Rounds have been completed on all resident areas to determine cleanliness and repair needed of furniture.</p> <p>3. Root Cause: The Environmental Director failed to develop and initiate a routine cleaning schedule for furniture. The Center Director of Environmental Services will create and submit a routine cleaning schedule for all center furniture on or before 7/31/2018.</p> <p>4. The CED and/or designee will perform weekly environmental rounds for 4 weeks to observe that furniture is cleaned according to schedule and remains in good condition until 100% compliance is obtained. The CED and/or designee will then perform routine monthly environmental rounds for 3 months to observe sustainability of the plan. The CED will report to the QAPI committee monthly for further evaluation and recommendations.</p>		
F 609	Reporting of Alleged Violations	F 609		7/31/18	

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NAME OF PROVIDER OR SUPPLIER  <b>MILFORD CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>700 MARVEL ROAD</b> <b>MILFORD, DE 19963</b>		
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F 609 SS=D	Continued From page 21 CFR(s): 483.12(c)(1)(4)  §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:  §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.  §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for one (R13) out of 53 sampled residents the facility failed to identify an allegation of neglect. This resulted in the facility failure to immediately report and thoroughly investigate the allegation. Findings include:	F 609	1. R13 remains in the center and receives appropriate care. No further allegations have been reported.  2. Any resident receiving care could be affected. No further allegations have been presented.		

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F 609	<p>Continued From page 22</p> <p>Review of R13's clinical record revealed:</p> <p>3/1/18 - Quarterly MDS Assessment documented severe cognitive impairment, extensive assistance with bed mobility and toileting, frequently incontinent of urine and always incontinent of bowel.</p> <p>6/13/18 2:01 PM - Interview with E16 (CNA) revealed that, on 6/10/18, R13 was found in the morning with dried / drying bowel movement (BM) and, had it not been R13's shower day, a shower would have been needed to remove the BM. E16 also reported concerns with wet sheets on other resident beds, used briefs being left on the floor in several rooms, dried blood on a resident's sheet and an oxygen concentrator found turned off. E16 stated that another aide (E15) reported these findings to E1 (NHA) who "disregarded as complaining".</p> <p>6/13/18 around 2:30 PM - Interview with E15 (CNA) revealed on 6/10/18 she found R13 with multiple dried urine stains on bed linens and the draw sheet had both dried urine and BM. R13 had dried BM on the scrotum and buttocks that had to be moistened in the shower in order to be cleaned off. E15 reported this to E13 (LPN) along with other concerns on the unit from the night shift. E15 added that E1 was made aware but E1 responded "is there any day you're not complaining?" E15 stated s/he spoke directly to the night aide who indicated s/he had worked a double (two shifts back to back) and the night aide "just blew me off."</p> <p>6/13/18 around 2:45 PM - Interview with E13 [LPN] confirmed that E15 shared the concerns about R13's care on 6/10/18. E13 said s/he</p>	F 609	<p>3. Root Cause: The staff identified failed to follow their duty to report per center policy OPS300. E15, E13, and E16 have all been educated on the center Abuse Prohibition policy OPS300 with the emphasis on their duty to report. All center staff will be educated on or before July 31, 2018 on policy OPS300 to include newly hired staff. The education will be provided by each department head.</p> <p>4. The center department heads will perform daily random audits on all three shifts to center staff in regards to questions related to policy OPS300. Department Heads will review findings at each morning meeting for 2 weeks, then monthly for 3 months. Department heads will document findings and immediately provide education for any staff unable to answer questions accurately. The CED will report a summary of findings to the QAPI committee monthly until 100% compliance is obtained.</p>		

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F 609	Continued From page 23 talked to the 11-7 nurse about it but added that it "does no good." When the surveyor inquired if E13 elevated this issue (to the manager) E13 said when I do they say "stop picking on them" meaning the 11-7 staff. E13 added that they took an aide off care but "management told me I was picking on them."  6/14/18 12:58 PM - Interview with E2 (DON) revealed that E2 was not made aware of any allegations of failure to provide care on during the night of Saturday 6/9/18. E1 (NHA) entered the conversation and told the surveyor no one had made an allegation of neglect to her. E1 stated she was only told about trash and linen on the floor. E1 and E2 denied being aware of R13 being found wet and with drying BM on his body. It was revealed that the process for reporting neglect would be for the aide to report concerns to the nurse and the nurse should report it to the unit manager or the on-call RN in the managers absence.  The facility failed to identify an allegation of neglect when E15 told E13 about the lack of care provided to R13. This resulted in a failure to immediately report and thoroughly investigate the allegation.  This findings was reveiwed with E1 [NHA] , E2 [DON] and E40 (CRN) at the exit conference on 6/15/18 at approximately 11:30 AM.	F 609			
F 637 SS=D	Comprehensive Assessment After Signficant Chg CFR(s): 483.20(b)(2)(ii)  §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the	F 637		7/31/18	



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F 637	<p>Continued From page 24</p> <p>resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview it was determined that a significant change MDS assessment was not completed after a decline in status for one (R35) out of 53 sampled residents. Findings include:</p> <p>Review of R35's clinical record revealed:</p> <p>12/22/17 - Annual MDS Assessment documented R35 was independent with transfer, walking in room, locomotion on unit and required extensive assistance with dressing, toilet use, personal hygiene. R35's balance was unsteady but able to stabilize without staff assistance and used a walker. No falls from prior assessment which was 10/4/17. The resident was occasionally incontinent of urine.</p> <p>3/16/18 - Quarterly MDS Assessment identified R35 needed supervision when walking in the room and now required extensive assistance with transfer when the resident was previously independent. R35's balance was steady at all times but had two or more falls since the December assessment. The resident was now frequency incontinent of urine, a decline in urinary continence.</p>	F 637	<p>1. R35 MDS had a significant change MDS completed on 6/15/2018. The MDS coordinator had identified the significant change from March to June MDS.</p> <p>2. Any resident who has a significant change as identified in F Tag 637 could be affected. A review of current residents MDS showed no other residents requiring a significant change MDS.</p> <p>3. Root Cause: The center lacked a systematic approach for nursing to communicate to the MDS staff. The Clinical Reimbursement Coordinator (CRC) will educate the unit Manager's on the requirements for significant change MDS. NEW PROCESS: Residents for a potential need for a significant change MDS will be identified at each clinical morning meeting through physician orders, and nursing staff documentation, and will be referred via a communication tool to the MDS staff to determine if a significant change MDS is required. The CRC will report back to the clinical team the determination made by</p>		

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F 637	Continued From page 25  The change was not identified nor was the need for a significant change MDS assessment.  During an interview with E18 (Clinical Reimbursement Analyst) on 6/8/18 at 10:09 AM to discuss how a decline in function is identified, E18 asked for time to investigate but stated that R35's care planning meeting was scheduled on 6/22/18.  On 6/8/18 at 3:38 PM E18 confirmed the decline was not identified in March and that a significant change assessment was scheduled prior to June 22 care plan meeting.  This findings was reviewed with E1 (NHA), E2 (DON) and E40 (CRN) during the exit conference on 6/15/18 at approximately 11:30 AM.	F 637	the MDS staff in regards to the MDS.  4. The center will continue this process as a new systematic approach to identifying significant changes to the MDS to include the initiation or revision of the Care Plan. The process will be evaluated by the CRC and the CNE monthly for 3 months to determine the effectiveness and to obtain 100% compliance.		
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 the facility failed to have MDS assessments that accurately reflected the resident's status for two (R97 and R49) out of 53 sampled residents. Findings include:  1. The following was reviewed in R97's clinical record:  3/22/18 - Dental examination by the dentist documented "partial upper denture in cup, unable	F 641	1. R97 and R49's MDS has been updated to reflect the current assessment of both residents.  2. An audit was performed on current residents with the use of bed alarms to determine accurate coding of section P of the their most recent MDS. The nursing staff will perform resident dental/mouth assessment on current residents on or before July 31, 2018 to reconcile the	7/31/18	

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F 641	<p>Continued From page 26</p> <p>to use after natural teeth broke off... partial denture cannot be repaired for use."</p> <p>5/11/18 - Quarterly MDS documented moderately cognitively impaired, no broken or loose fitting full or partial denture (chipped, cracked, uncleanable or loose).</p> <p>6/13/18 9:30 AM - Interview with R97 revealed that she could not wear her partial denture and she would like a new one.</p> <p>The MDS incorrectly coded R97's unuseable partial dentures.</p> <p>2. The following was reviewed in R49's clinical record:</p> <p>12/7/16 2:00 PM - Physicians' ordes included to please place fall mats and bed alarm.</p> <p>12/7/16 - Care Plan for falls with the intervention initiated: bed alarm to bed to alert staff members of resident's need to ambulate.</p> <p>R49's MDS Assessments did not include the resident had a bed alarm: - Quarterly MDS: 10/12/17 and 4/4/18. - Annual MDS: 1/3/18.</p> <p>Observations of R49 in bed with alarm in place: 6/5/18 (1:40 PM); 6/11/18 (8:40 AM) and 6/12/18 (10:00 AM).</p> <p>6/13/18 1:20 PM - Interview with E18 (RNAC) reviewed the clinical record and confirmed that the MDS assessments listed above were not accurate and should have included the use of R49's bed alarm.</p>	F 641	<p>resident assessment with the MDS coding.</p> <p>3. Root Cause: The MDS staff did not view the C.N.A. point of care documentation to identify the use of the alarm. The nursing staff did obtain the dental consult for the change in the dental assessment on the nursing expanded assessment tool. The CNE will educate licensed nursing staff on accuracy of the dental section of the Nursing Expanded assessment that pull to the scheduled MDS. New process: The MDS staff will review the C.N.A. point of care documentation to identify residents utilizing alarms for the purpose of MDS coding. Dental consult reports will be reviewed at each clinical morning meeting to reconcile the information with the residents medical record to include the MDS.</p> <p>4. MDS audits will be performed by the CRC on 10% of weekly scheduled MDS's to determine accuracy of Section L Oral/Dental Status and Section P Restraint/Bed Alarms weekly for 4 weeks, then monthly for 3 months until 100% compliance is achieved on MDS accuracy. The CRC will report findings at the monthly QAPI until resolved.</p>	
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F 641	Continued From page 27 Findings reviewed on 6/15/18, at approximately 11:30 AM with E1 (NHA), E2 (DON), and E40 (CRN) during the exit conference.	F 641			
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2)  §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes:  §483.20(e)(1) Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care.  §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to notify the appropriate State Agency, DMMA PAS Unit (Division of Medicaid and Medical Assistance Pre-Admission Screening Unit), of the need to complete a Resident Review after a change in status related to a mental illness for one (R101) out 53 sampled residents. In addition, the facility failed to have a policy / procedure or a system in place to identify residents needing a PASRR (Pre-Admission Screening Resident Review).	F 644	1. R101 was referred to the PASRR unit for an updated PASRR. No specialized services were identified as needed.  2. Any resident with a change in diagnosis for mental illness or related condition could be effected. An audit will be performed by the Director of Social Services on or before 7/31/2018 to identify any resident needing a new referral and PASRR completion.	7/31/18	

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F 644	<p>Continued From page 28</p> <p>Findings include:</p> <p>Federal Regulations require completion of the PASRR to screen persons for possible mental illness, mental retardation or related conditions who are applying to or residing in a Medicaid certified nursing facility. After a change in status related to a mental illness, the facility is responsible for notifying the appropriate State agency of need for a PASRR resident review to ensure needed services are provided.</p> <p>The following was reviewed in R101's clinical record:</p> <p>11/5/14 - The acute care hospital social worker (SW) who was transferring R101 to the facility completed the State's "Determination of Need for PASRR Assessment" form as: NO INDICATION of mental illness, mental retardation/related conditions - appropriate for admission/continued stay.</p> <p>11/5/14 - Resident was admitted to the facility from an acute care hospital.</p> <p>11/12/14 - Admission MDS Assessment revealed that R101 did not have a schizophrenia diagnosis and was not on anti-psychotic medications.</p> <p>6/19/17 - Quarterly MDS Assessment added a new diagnosis of schizophrenia, and included that R101 was taking anti-psychotic medications.</p> <p>The following MDS Assessments all included that R101 had a diagnosis of schizophrenia and was taking anti-psychotic medications: - Quarterly: 9/7/17; 11/23/17 and 5/24/18. - Annual: 2/13/18.</p>	F 644	<p>3. New Process: The MDS staff will report to the Director of Social Services any newly added diagnosis for mental illness or related conditions to the MDS in order to obtain referral and completion of an updated PASRR. The clinical team will review and report any new physician orders relating to newly diagnosed mental illness or related conditions to the Director of Social Service.</p> <p>4. The Director of Social Services will audit 10% of current residents MDS weekly for 4 weeks, then monthly for the next 3 months or until 100% compliance is achieved. Social services will report to the QAPI committee monthly for further recommendations and evaluations to sustain the new process.</p>	

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F 644	Continued From page 29  6/7/18 4:00 PM - Interview: E1 (NHA) confirmed no PASRR had been completed since the PASRR that was completed by the acute care hospital SW prior to admission to the facility in 2014. E1 confirmed that the facility does not have a policy / procedure related to PASRR.  6/14/18 10:00 AM - Interview: E7 (SW) confirmed that the State agency has not been notified of R101's diagnosis of schizophrenia, but would do so immediately.  6/14/18 11:00 AM - Interview: E18 (RNAC) confirmed that the first time a schizophrenia diagnosis was added to R101's MDS was in the 6/19/17 Quarterly MDS.  Findings reviewed on 6/15/18, at approximately 11:30 AM with E1, E2 (DON), and E40 (CRN) during the exit conference.	F 644			
F 655 SS=E	Baseline Care Plan CFR(s): 483.21(a)(1)-(3)  §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to-	F 655		7/31/18	

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F 655	<p>Continued From page 30</p> <p>(A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable.</p> <p>§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-</p> <p>(i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).</p> <p>§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:</p> <p>(i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to have a system to ensure residents and / or their representative were provided a written summary of the baseline care plan including initial goals, services, treatments, resident's medications and dietary instructions for four (R36, R79, R102 and R273) out of 53 sampled residents with an admission date on or after the regulation</p>	F 655	<p>1. For R36, R79, R201, R273, the time to complete the 72 hour baseline care plan has passed. The center is unable to correct. All 4 residents currently have a comprehensive care plan in place.</p> <p>2. Any new admission could be affected. A review of new admissions from 6/15/2018 to current has been completed and</p>		

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F 655	Continued From page 31 implementation date of 11/28/18. Findings include:  1. Record review for R36 revealed: R36 was admitted on 3/16/18. No evidence that a baseline care plan written summary was provided to the resident and/or responsible party was found during review of the record.  2. Record review for R79 revealed: R79 was admitted on 2/7/18. No evidence that a baseline care plan written summary was provided to the resident and/or responsible party was found during review of the record.  3. Record review for R102 revealed: R102 was admitted on 5/18/18. No evidence that a baseline care plan written summary was provided to the resident and/or responsible party was found during review of the record.  4. Record review for R273 revealed: R273 was admitted on 6/1/18. No evidence that a baseline care plan written summary was provided to the resident and/or responsible party was found during review of the record.  6/12/18 3:07 PM - Interview with E7 (SW) confirmed that the facility had not initiated the practice of providing the baseline care plan written summary to residents and / or their responsible party. E7 revealed that the facility plans to implement this requirement.  Findings reviewed on 6/15/18, at approximately	F 655	comprehensive care plans have been initiated.  3. Social Services and interdisciplinary team (IDT) has been informed by the CED on the requirement of 483.21(a)(1)-(3) Baseline Care Plan. New Process: The IDT will meet with each new resident within 72 hours and provide a copy of the physician order sheet (POS). The POS will be reviewed with the resident and/or the responsible party and social services will document the meeting in the 72 hour assessment note.  4. The CED and/or designee will perform routine record reviews of all new admissions every 3 days for 2 weeks, then weekly for 3 weeks, then monthly for 2 months or until 100% compliance is met. The CED will report findings at each morning meeting to determine the need for further evaluations and or recommendations.		



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F 655	Continued From page 32 11:30 AM with E1 (NHA), E2 (DON), and E40 (CRN) during the exit conference.	F 655			
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	F 656		7/31/18	

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F 656	<p>Continued From page 33</p> <p>community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.</p> <p>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview it was determined that the facility failed to develop a comprehensive care plan for two (R40, and R50) out of 53 sampled residents for identified needs. Findings include:</p> <p>Cross Refer F676, example 1</p> <p>1. Review of R40's clinical record revealed:</p> <p>6/27/17 - Care plan for Risk for decreased ability to perform ADLs (last revised 9/14/17) had the goal that R40 will maintain the highest capable level of ADL ability. Interventions included to monitor for conditions that may contribute to ADL decline; and arrange environment as much as possible to facilitate ADL performance.</p> <p>This care plan did not include R40's level of functioning nor did it include specific interventions to arrange the environment to maintain or improve ADLs.</p> <p>Cross refer F679, Example #1.</p> <p>2. Review of R50's clinical record revealed the following:</p> <p>9/27/17 - R50 admitted to the facility.</p> <p>10/4/17 - The annual MDS Assessment, stated R50's cognitive skills were moderately impaired. The same MDS regarding R50's interview of</p>	F 656	<p>1. R40 and R50 care plans have been reviewed and revised to reflect the current status and preferences.</p> <p>2. Any resident requiring a care plan for ADL's and Activities could be affected. An audit for the Memory Care Unit residents and current residents activities care plan will be performed on or before July 31, 2018. Current resident care plans will be reviewed at each quarterly or annual care plan review for accuracy and appropriate interventions.</p> <p>3. Root Cause: Vacant Director position. The new Activity Director and Dementia Director have been educated to 483.21(b) (1) Develop/Implement Comprehensive Care Plan by the CED and/or the CNE.</p> <p>4. Audits for 10% of weekly scheduled care plans will be performed by the CNE or ADON weekly for 4 weeks, then monthly for 2 months or until 100% compliance is met. Findings will be reported to the QAPI committee monthly until resolved at 100% compliance.</p>	

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F 656	Continued From page 34 preferences for customary routine and activity stated that the following were "very important" to R50: listening to music she likes, keeping up with news, being around animals such as pets, doing things with group of people, and participating in religious services or practices. The assessment further documented the resident enjoys books but must be read to due to poor vision, enjoys audio books, enjoys 70s music, likes dogs, news on TV, catholic activities The MDS stated that the following activities were somewhat important: to do favorite activities. R50 required extensive assist of one staff for bed mobility, transfer, walk in room and corridor and locomotion on and off the unit.  There was no care plan developed to address R50's activity needs or interests.  6/13/18 at approximately 2:06 PM - An interview with E34 (Activity Director) revealed that she began her employment on 4/30/18 and confirmed R50 lacked a care plan for activities.  Findings reviewed on 6/15/18, at approximately 11:30 AM with E1 (NHA), E2 (DON), and E40 (CRN).	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.	F 657		7/31/18	

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F 657	<p>Continued From page 35</p> <p>(B) A registered nurse with responsibility for the resident.</p> <p>(C) A nurse aide with responsibility for the resident.</p> <p>(D) A member of food and nutrition services staff.</p> <p>(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.</p> <p>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.</p> <p>(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, observation and interview it was determined that the facility failed to revise the care plan for four (R33, R35, R40 and R75) out of 53 sampled residents to reflect current status and needs. Findings include:</p> <p>1. Review of R33's clinical record revealed:</p> <p>7/28/16 - Care plan initiated for at risk for skin breakdown including the following interventions: Evaluate for any localized skin problem, i.e. dryness, redness . . . inflammation; Monitor skin for signs/symptoms of skin breakdown, Skin risk assessment assessment per policy; Observe skin condition with ADL care daily and report abnormalities; Pressure redistribution surfaces to bed; Provide pericare/incontinence care as needed; Turn and/or reposition and check skin</p>	F 657	<p>1.R33, R35, R40, and R75 care plans updated to reflect the current resident's status.</p> <p>2. Any current resident care plan could be affected. Care plan audits will be performed at each physician order change and/or when there is a change is resident condition to include each next quarterly or annual due date for accuracy and completion.</p> <p>3. Unit Managers and the Dementia Director will be educated by the CNE on the requirements of 483.21(b)92)(1)-(iii) Care plan Timing and revision on or before July 31, 2018. Care Plans will be reviewed at each clinical meeting by the</p>	

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F 657	<p>Continued From page 36</p> <p>every 2 hours or as specified by plan of care (initiated 1/10/18 and revised 2/5/18); Weekly skin assessment by licensed nurse.</p> <p>6/5/18 4:40 PM - Observation of R33 in bed with boot to left foot.</p> <p>6/5/18 4:40 PM - Interview with E25 (CNA) revealed s/he had completed the first round and that the boot was not on the CNA care plan nor on the pressure ulcer care plan.</p> <p>6/5/18 5:00 PM - Interview with E33 (LPN) stated the intervention for the boot would be on the TAR but not on the CNA care plan.</p> <p>6/6/18 8:25 AM - Observational interview with E60 (CNA) revealed the boot was now on R33's right foot and would be documented in the CNA tracker as well as being told by the nurse.</p> <p>06/07/18 09:01 AM - Observation of R33 in bed with boot on right foot.</p> <p>The care plan was not revised to include the use of the boot, and on which foot it should used.</p> <p>2. Review of R35's clinical record revealed the last care plan review was completed 4/22/18:</p> <p>2/15/16 - Care plan for Risk for falls due to Parkinsons Disease, advanced dementia with the goal to have no falls with injury. Interventions included: Maintain a clutter free environment in the resident's room and consistent furniture arrangement. Additional interventions subsequently added:</p> <ul style="list-style-type: none"> <li>- 5/31/16: Bed against wall on one side; monitor for and assist toileting needs.</li> <li>- 9/2/16: 1/4 [one quarter] rail as enabler.</li> <li>- 9/8/16: Observe resident in room throughout</li> </ul>	F 657	<p>unit manager's and the CNE with each residents physician order change for accuracy and revisions.</p> <p>4. The CNE will audit 10% of care plans weekly for 4 weeks, then monthly for 2 months or until 100% compliance is obtained. The CNE will report to the QAPI committee monthly for further recommendations and evaluations until resolved.</p>	

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F 657	<p>Continued From page 37</p> <p>the shift to see that R35 has put the foot of the recliner down; remind resident to put foot of recliner down before exiting.</p> <ul style="list-style-type: none"> <li>- 8/23/17: Encourage (as able) resident to engage in seated activities and/or rest when observed as being sleepy while walking.</li> <li>- 8/27/17: Provide verbal cues for safety and sequencing when needed.</li> <li>- 9/13/17 : Bed alarm, pressure pad.</li> <li>- 10/2/17: Assist resident as needed with transferring from dining room table chairs, monitor to make sure she does not attempt to stand with items in her hands; assist with getting in and out of bed with assist of walker.</li> </ul> <p>11/22/16 - Care plan problem for ADLs (last reviewed 5/7/18) included R35 was independent with transfers and ambulation, and required limited assistance for toileting and personal hygiene.</p> <p>12/22/17- Annual MDS Assessment documented no falls from prior assessment which was 10/4/17.</p> <p>3/16/18 - Quarterly MDS Assessment identified R35 needed supervision when walking in the room and now required extensive assistance with transfer. R35's balance was steady at all times but had two or more falls since the December assessment.</p> <p>March - May 2018 - Review of change of condition notes discovered R35 had 4 falls since the March MDS assessment: March 31, April 6, May 18 and May 26.</p> <p>The facility failed to review and revise R35's care plan after the resident experienced numerous</p>	F 657			

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F 657	<p>Continued From page 38</p> <p>falls since December, 2017 and now needed extensive assistance with transfer.</p> <p>3. Review of R40's clinical record revealed:</p> <p>7/19/17 - Care plan for Risk for falls related to cognitive loss and poor safety awareness included the following interventions: Provide resident/caregiver education for safe techniques; place call light within reach while in bed or close proximity to the bed; when resident is in bed, place all necessary personal items within reach; monitor for and assist toileting needs. Additional interventions subsequently added:</p> <ul style="list-style-type: none"> <li>- 2/9/18: Supervision when out of bed.</li> <li>- 4/7/18: Bed alarm to bed to alert staff members of resident's need to ambulate at night only.</li> <li>- 5/1/18: Utilize low bed; maintain a clutter-free environment in the resident's room and consistent furniture arrangement.</li> </ul> <p>Observations discovered the fall mat at the bedside and the bed alarm was turned on during day time hours: 6/5/18 (9:55 AM); 6/7/18 (8:21 AM and 3:45 PM) and 6/8/18 (9:34 AM).</p> <p>R40's care plan had not been revised to include the fall mat or use of the bed alarm during day time hours.</p> <p>4. Cross refer F758 example #1. The following was reviewed in R75's clinical record:</p> <p>R75 had diagnoses which included dementia, anxiety, depression and agitation.</p> <p>5/17/17 - Care plan for at risk for complications related to the use of psychotropic drugs medication: antidepressant, antianxiety.</p>	F 657			

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F 657	<p>Continued From page 39</p> <p>Approaches included; complete behavior monitoring flow sheet; monitor for continued need for medication as related to behavior and mood.</p> <p>10/31/18 - Care plan for disruptive demanding behaviors as evidenced by demanding immediate attention even if you are with another resident (repeatedly requesting to toilet even after toileting done - most often no results)</p> <p>2/5/18 - Care plan for disruptive demanding behavior as evidenced by repetitive calling out "help me" even when staff have helped resident.</p> <p>3/1/18 - Care plan for exhibits or is at risk for distressed / fluctuating mood symptoms related to recent changes affecting functional loss.</p> <p>3/14/18 3:39 PM - progress note "[name of mental health provider] evaluation for increased delusions and paranoia..."</p> <p>3/19/18 - Provider note ...referral made to [name of mental health provider] last week due to increasing delusions and hallucinations per staff and daughter. Monitor mood and behaviors...psychotic disorder with delusions due to known physiological condition...was receiving an antipsychotic daily but was it discontinued and resident was tolerating well. Per daughter and staff delusions present now...</p> <p>3/21/18 - New physician's order for an antipsychotic for paranoid delusions.</p> <p>Review of the care plan lacked evidence that the new onset of paranoid delusions and subsequent need for anti-psychotic medication was addressed.</p>	F 657		



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F 657	Continued From page 40  6/13/18 9:18 AM - Interview with E10 (RN) and E5 (Dementia Director) provided no further information on updating the care plan.  Findings reviewed on 6/15/18, at approximately 11:30 AM with E1 (NHA), E2 (DON), and E40 (CRN) during the exit conference.	F 657			
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii)  §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that:  §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ...  §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living:  §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care,  §483.24(b)(2) Mobility-transfer and ambulation, including walking,	F 676		7/31/18	

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F 676	<p>Continued From page 41</p> <p>§483.24(b)(3) Elimination-toileting,</p> <p>§483.24(b)(4) Dining-eating, including meals and snacks,</p> <p>§483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to provide services to maintain or improve ADLs in the area of ambulation and eating for three (R7, R40 and R75) out of 53 sampled residents. Findings include:</p> <p>Cross Refer F689.</p> <p>1. Review of R40's clinical record revealed:</p> <p>6/27/17 - Care plan for Risk for decreased ability to perform ADLs had the goal that R40 will maintain the highest capable level of ADL ability. Interventions included to monitor for conditions that may contribute to ADL decline; and arrange environment as much as possible to facilitate ADL performance.</p> <p>7/3/17 - Admission MDS Assessment documented R40 had moderate cognitive impairment, needed supervision with toileting but was independent with bed mobility, transfer and walking in the room / hallway.</p> <p>9/27/17 - Significant Change MDS Assessment recorded R40 had severe cognitive impairment but remained independent with bed mobility, transfer and walking in the room / hallway.</p>	F 676	<p>1. R7, R40, R75 have been re-assessed by therapy for Dining ADL's.</p> <p>2. Any resident with a decline in ADL's could be affected. Center will identify ADL declines through the most recently completed MDS and the MDS staff to include the next scheduled MDS to be completed.</p> <p>3. Certified nursing assistants staff will be educated by CNE or designee on or before July 31, 2018 on identification of ADL decline and reporting to nurse manager and/or nurse supervisor for further evaluation.</p> <p>4. The CRC will perform weekly MDS audits for ADL decline or improvement for 4 weeks, then monthly for 3 months or until 100% compliance is obtained. The CRC will report findings to the QAPI committee for further recommendations or evaluations until resolved.</p>		

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F 676	<p>Continued From page 42</p> <p>Resident improved and now was independent with toileting.</p> <p>12/14/17 - Readmission note included that R40 returned from a two-day hospital stay for unsteady walking, confused speech and falls. MRI showed a new stroke in the brain.</p> <p>12/23/17 and 3/23/18 - Quarterly MDS Assessments documented severe cognitive impairment with the need for limited assistance with bed mobility, transfer, walking in room / hallway. R40 now needed extensive assistance with toileting.</p> <p>5//16/18 - Physical Therapy Discharge Summary from receiving therapy after recent fall and dragging right foot while walking documented R40 was discharged from receiving therapy since "maximum potential achieved, referred to . . . FMP" (Functional Maintenance Program).</p> <p>March - May 2018 - Review of R40's CNA documentation discovered a change in ambulation with the walker on the day and evening shift:</p> <ul style="list-style-type: none"> <li>- Locomotion on the unit: 77.4% in March to 11.3% in May, a decline.</li> <li>- Walk in the corridor: 74.2% in March to 27.4% in March, a decline.</li> <li>- Use of wheelchair for locomotion increased from 0% in March to 88.5% in May as the use of the walker decreased.</li> </ul> <p>During an interview with E42 (PT) on 6/8/18 at 10:30 AM to review R40's progress and discharge goals from the service ending 5/16/18, E42 stated that R40 was "independent with ambulation using the walker" but the resident's "right foot would</p>	F 676			

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F 676	<p>Continued From page 43</p> <p>start dragging" after walking a longer distance like 50 feet. The physical therapist said "I did not do FMP" since E42 did not want the resident to have to wait for someone to walk. E42 stated the expectation for R40 was to continue to walk independently with the walker. E42 added that bright color tape was attached to the walker to aid R40 in seeing it due to visual impairment.</p> <p>During an interview with E12 (RN) on 6/8/18 at 10:55 AM, the surveyor reviewed the discussion with the physical therapist and R40's goal for ambulation.</p> <p>It was unclear why R40 was not referred to FMP when it was a goal of physical therapy's discharge summary.</p> <p>2. Review of R75's clinical record and observation revealed: 6/8/18 (9:05 - 9:20 AM) - Observation of R75 being served breakfast consisting of a large pancake with syrup. The resident attempted to use the fork to cut the pancake was unable. R75 spilled syrup onto her pants as the pancake moved toward the front of the plate during the attempted cutting. Another resident seated at the same table got E5's (Dementia Director) attention when R75 said s/he could not cut up the pancake. E5 approached the table and asked the resident "Do you usually need help cutting up your food? Would you like me to cut it into bite sized pieces?" E5 proceeded to cut up the pancake for the resident. R75 proceeded to eat the pancake without difficulty.</p> <p>3. 6/8/17 (12:20 PM) - Observation during lunch of R7 putting a brown paper towel napkin into his/her cup after consuming 2/3 of the thickened</p>	F 676		

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F 676	Continued From page 44 juice. R7 used a fork to eat the thickened juice. No staff was supervising R7 while s/he continued this activity for 8 minutes. Afraid the resident would eat the paper towel, the surveyor informed E5 (Dementia Director) and E10 [RN] at 12:28 PM. E10 took R7's cup with the paper towel and prepared the resident a new cup of thickened juice.  These findings were reviewed with E1 (NHA), E2 (DON) and E40 (CRN) on 6/15/18 at approximately 11:30 AM during the exit conference.	F 676			
F 679 SS=E	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1)  §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observations and interview, it was determined that the facility failed to ensure that two residents (R50 and R33) out of 53 sampled residents and one (Homestead unit) out of 3 nursing units, received an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.	F 679	1. R50, and R33 activity assessment and care plan has been initiated and/or revised.  2. Any current resident could be affected. An audit on Activity Care plans for current residents will be performed before July 31, 2018 to identify residents who need an activity care plan initiated or revised.	7/31/18	

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F 679	<p>Continued From page 45</p> <p>Findings include:</p> <p>Cross refer F656, Example #2.</p> <p>1. Review of R50's clinical record revealed the following:</p> <p>9/27/17 - R50 admitted to the facility.</p> <p>10/4/17 - Annual MDS Assessment, stated that R50's cognitive skills were moderately impaired and preferences for customary routine and activity stated that following were "very important" to R50: listening to music she likes, keeping up with news, being around animals such as pets, doing things with group of people, and participating in religious services or practices. The assessment further documented she enjoys books but must be read to due to her vision, enjoys audio books, enjoys 70s music, likes dogs, news on TV, catholic activities The MDS stated that the following activities were "somewhat important: to do favorite activities. R50 required extensive assist of one staff for bed mobility, transfer, walk in room and corridor and locomotion on and off the unit. There was no care plan developed to address activity needs or interest.</p> <p>4/1/18-6/9/18 - Resident Participation Record documented total of four activities during this 70 days period of time as follows:</p> <ul style="list-style-type: none"> <li>- April 2018: One family/friend visit..</li> <li>- May 2018: One family/friend visit.</li> <li>- June 1-13, 2018: One creative arts and one special events.</li> </ul> <p>There was no evidence that the resident was given an opportunity to participate in activities of her interest, including listening to music she likes, keeping up with news, being around animals such</p>	F 679	<p>3. The new activities director has been educated on Center Policy REC204 Individual Program Planning and 483.21(c)(1) Activities Interest/Needs....The activity director and the dementia director will develop a daily calendar of events for the memory care unit.</p> <p>4. The dementia director will perform daily observations of residents activity in the memory unit and report findings at each morning meeting to the activity director for the next 4 weeks, then monthly for the next 3 months. The activity director and/or designee will audit resident participation records weekly for 4 weeks, then monthly for 3 months or until 100% compliance is obtained. The activity director will report findings to the QAPI committee for further recommendations and evaluation for improvement until resolved.</p>	

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F 679	<p>Continued From page 46</p> <p>as pets, doing things with group of people, and to participate in religious services or practices.</p> <p>6/4/18, 6/5/18, 6/6/18, and 6/7/18 - Multiple observations from approximately 9:00 AM to 4:30 PM revealed R50 in bed listening to the TV. No additional meaningful activity was observed.</p> <p>6/13/18 at approximately 2:06 PM - An interview with E34 (Activity Director) revealed that she began her employment on 4/30/18 and E34 verbalized s/he recently hired additional activities staff in an effort to meet the department's need. E51 (RA, Recreational Assistant) began employment on 6/7/18. E34 confirmed the lack of activities for R50.</p> <p>2. Review of R33's clinical records revealed:</p> <p>7/28/16 - R33 admitted to the facility.</p> <p>7/28/16 - The care plan for at risk for limited and/or meaningful engagement related to cognitive loss / dementia included a goal that R33 would increase level of participation in activities as evidenced by attending in increased socialization, increased verbalization of satisfaction in involvement, increase attendance and participation per participation log revised on 6/5/18.</p> <p>Interventions included:</p> <ul style="list-style-type: none"> <li>- Beauty salon once a week to get hair washed and set.</li> <li>- Enjoys cake, cookies, candy.</li> <li>- Try to sit resident near the leader of activity so she can hear and see the activity.</li> <li>- Encourage participation in music, TV movies, socialization, outdoor activities, hand massage.</li> <li>- Provide cueing through physical prompts,</li> </ul>	F 679		

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F 679	<p>Continued From page 47</p> <p>physical assistance, verbal direction to enable successful participation in activity.</p> <p>7/5/17 - The annual MDS assessment, stated R33 's cognitive skills were moderately impaired and staff interview of preferences for customary routine and activity stated the following as R33's activities of interest: listening to music she likes, doing favorite activities, and going outside when the weather is nice. The MDS stated R33 required extensive assist of one staff for bed mobility and transfer and extensive assistance of two staff for walking and locomotion.</p> <p>4/6/18 - R33 transferred from the secured unit to long term care unit.</p> <p>4/8/18 through 6/7/18 - Review of the Resident Participation Record revealed the following: April 8-30, 2018: One spiritual activity, one family/friend visit, and one time in which nails were manicured. May, 2018: One spiritual activity and one special event. June 1-7, 2018: Five spiritual programs.</p> <p>6/4/18, 6/5/18, 6/6/18 and 6/7/18 - Multiple observations from approximately 9:00 AM. to 4:30 PM revealed R33 in bed with eyes closed with no meaningful activity.</p> <p>6/8/18 at 9:50 AM - Surveyor observed R33 being transported to the Activity's Room for a group activity and returned to her room at 11:39 AM at the conclusion of the event.</p> <p>6/8/18 at 11:30 AM - An interview with E50 (Business Office Staff) revealed the following dates in which R33 had her salon service:</p>	F 679			



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F 679	<p>Continued From page 48</p> <p>4/5/18, 4/26/18, 5/10/18, and 5/17/18. It is unclear how the facility monitored and ensured R33 had an opportunity for this meaningful activity.</p> <p>6/8/18 at 11:30 AM - An interview with E50 (Business Office Staff) revealed the following dates in which R33 had her salon service: 4/5/18, 4/26/18, 5/10/18, and 5/17/18.</p> <p>6/12/18 at 8:26 AM - An interview with E34 (AD) revealed R33 was transferred from the secured unit on 4/7/18. E34 indicated that s/he will be completing a Recreation Assessment due to transition from a secured unit in which structured activities are performed for the residents in the unit. The above information on the Resident Participation Record was reviewed and the salon services performed were reviewed with E34. During the above 100 days of review, the facility had evidence of five activities.</p> <p>6/15/18 at approximately 11:45 AM - During the exit meeting, E1 (NHA) verbalized that the reason R33 was not provided weekly salon services was due to unpaid expenses which was resolved during the survey and R33 resumed her salon services on 6/14/18.</p> <p>3. 6/08/17 (9:30 AM - 11:00 AM) - Observation on the Homestead unit revealed no activities were conducted. The dry erase board in the activity area still contained the menu and date from the previous day (6/7/18).</p> <p>During an interview with E5 (Dementia Director) on 6/8/18 around 11:10 AM to inquire about activities, E5 stated "[First name of recreation assistant] is not here" and indicated there was no replacement for his/her days off. Within 10 minutes E5 enlisted E12's (ADON) assistance to</p>	F 679		

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F 679	Continued From page 49 gather residents to conduct a trivia activity.	F 679			
F 684 SS=E	<p>These findings were reviewed with E1 (NHA), E2 (DON) and E40 (CRN) during exit conference on 6/15/18 at approximately 11:30 AM.</p> <p>Quality of Care CFR(s): 483.25</p> <p>§ 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to provide care and services according to professional standards, physicians' orders and facility policy for four (R35, R40, R102 and R273) out of 53 sampled residents. Findings include:  3/1/98 - Facility policy entitled Neurological Assessment (last reviewed 3/1/16) included that a neurological assessment will be performed as indicated or ordered. When a patient sustains an injury to the head and / or has an unwitnessed fall, neurological assessment will be performed every 30 minutes for two hours, then every 1 hour for 4 hours, then every 4 hours for 24 hours.  Neurological assessment (neuro checks) looks for signs of head injuries. The resident should be assessed immediately after the fall, then</p>	F 684	<p>1. R35 and R40's neuro checks were unable to be corrected. R40's BP monitoring has been reviewed and is currently being completed. R273's medication is being given as ordered. R102 no longer resides at the center effective July 3, 2018.</p> <p>2. Current residents who requires neuro checks could be affected. Current residents receiving medications could be affected. Current residents on fluid restrictions with IV 's could be affected. Current residents with a PICC line could be affected. Current residents receiving PICC line management, fluid restrictions and or neuro checks have had a medical record review to identify discrepancies and the need for interventions.</p>	7/31/18	

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F 684	<p>Continued From page 50</p> <p>frequently throughout the shift (Source: LTC Clinical Pearls: Powered by HCPro's Long-Term Care Nursing Library, January 8, 2013).</p> <p>Neurological Assessments Change of Condition notes and Neurological Assessment Flow Sheets reflected that R35 experienced unwitnessed fall or falls with head injury. There was inconsistency in utilizing the legend at the bottom of the flow sheet to record assessment findings, making the accuracy unclear. In addition the frequency outlined in the facility policy was often not followed.</p> <p>1. Review of R35's clinical record revealed many falls: - 3/16/18: unwitnessed fall (missing 3 of the every 4 hour assessments). - 3/31/18: unwitnessed fall (missing 3 of the every 30 minute and 4 of the every 1 hour assessments as only vital signs were performed). - 4/6/18: unwitnessed fall (missing level of consciousness, pupil response and motor function after return from ER; missing 1 of the every 4 hour assessments).</p> <p>During an interview with E5 (Dementia Director) and E10 (RN) on 6/7/18 at approximately 1:10 PM to review the missing and incomplete neurological checks, no additional information was provided during the survey.</p> <p>2A. Review of R40's clinical record revealed many falls: - 11/18/17: unwitnessed fall (missing 1 every 30 minute; missing 2 every 4 hour assessments). - 12/14/17: unwitnessed fall (missing level of consciousness, pupil and motor response for the first 3 every 30 minute assessments as only vital</p>	F 684	<p>3. Unit managers will perform audits daily on any residents receiving neuro checks, fluid restrictions, and PICC line management for 2 weeks, then weekly for 4 weeks, then monthly for 3 months or until 100% compliance is obtained. The ADON and unit managers will perform daily audits of the MAR for 2 weeks, then weekly for 4 weeks, then monthly for 3 months until 100% compliance is obtained. The findings will be reported to the CNE for further evaluation and system recommendations.</p> <p>4. The nurse managers and the ADON will report findings to the CNE. The CNE will review findings daily for 2 weeks, then weekly for 2 weeks, then monthly for 3 months to determine the need for further interventions. The CNE will report findings to the QAPI committee monthly for further with recommendations and evaluations until 100% compliance is obtained.</p>	

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F 684	<p>Continued From page 51</p> <p>signs were completed; missing 1 every 30 minute assessment; missing 2 every 4 hour assessments).</p> <ul style="list-style-type: none"> <li>- 1/31/18: unwitnessed fall (missing entire neurological assessment flowsheet).</li> <li>- 2/2/18: unwitnessed fall(missing 1 every 30 minute and 3 of the every 4 hour assessments).</li> <li>- 2/17/18: unwitnessed fall (missing pupil assessments for all entries, legend not used).</li> <li>- 3/29/18: fall and hit head on wall (missing all pupil checks).</li> <li>- 4/6/18: unwitnessed fall (missing pupil and motor function assessments for all entries).</li> </ul> <p>Blood Pressure Monitoring</p> <p>2B. March - May 2018 - Review of R40's MARs showed the resident received blood pressure medications that were to be held if the blood pressure was under a certain number. Nurses recorded the blood pressure on the MAR. The following 8:00 PM administrations of a blood pressure medication did not include the blood pressure assessment to determine if the physician parameter to hold the medication was followed:</p> <ul style="list-style-type: none"> <li>- March 16-30 (15 doses).</li> <li>- April 16, 19, 20 and 21.</li> </ul> <p>During an interview with E5 (Dementia Director) and E10 (RN) on 6/7/18 at approximately 1:10 PM to review the missing and incomplete neurological checks and missing blood pressures. E10 indicated s/he would check the thinned records for the missing neurological assessment flow sheet.</p> <p>3. Review of R273's clinical record revealed:</p> <p>6/1/18 - R273 admitted</p>	F 684			

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F 684	<p>Continued From page 52</p> <p>6/1/18 POS - oxycodone 5mg every 6 hours PRN for 3 days</p> <p>6/5/18 Controlled Substances Logbook - this medication, using this order, was given 3 times on 6/5, at 12:30 AM, 7:45 AM and 2:45 PM</p> <p>During an interview on 6/14/18 at 1:08 PM, E45 (RN) confirmed findings found in Controlled Substances Logbook.</p> <p>4. The following was reviewed in R102's clinical record:</p> <p>5/18/18 - Admitted to the facility from hospital.</p> <p>A. DIALYSIS</p> <p>5/18/18 - Original physicians' orders included fluid restriction of 1000 mL.</p> <p>5/22/18 - Care plan for nutrition included the intervention of 1000 mL fluid restriction.</p> <p>5/23/18 - Physicians' orders increased R102's fluid restriction to 1200 mL.</p> <p>5/25/18 - Admission MDS Assessment documented R102 required extensive assistance with one person support for eating and was legally blind.</p> <p>May 2018 - June, 2018 - Review of MARs found nurses documented the fluids administered by nursing.</p> <p>May, 2018 - June, 2018 - CNA Task list did not include an approach to document fluid intake and did not include the 1200 mL fluid restriction.</p> <p>6/14/18 8:46 AM - Interview with E46 (private</p>	F 684			

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F 684	<p>Continued From page 53</p> <p>aide) revealed that R102's fluid intake was not reported to facility staff.</p> <p>6/14/18 8:46 AM - Interview with E43 (CNA) reported that fluid intake was not recorded on R102's CNA task list and did not report fluid intake to the nurse.</p> <p>The facility failed to have system in place to monitor R102's fluid intake to ensure the resident did not receive too much or too little fluid by mouth.</p> <p><b>B. IV SITE</b></p> <p>The facility's policy for PICC lines (last revision date 10/1/18) included:</p> <ul style="list-style-type: none"> <li>- Sterile dressing change using transparent dressing is performed 24 hours post insertion and at least weekly.</li> <li>- Length of external catheter is obtained 24 hours post (after) insertion or upon admission.</li> <li>- Upper arm circumference upon admission (if no insertion measurement available) and then weekly.</li> </ul> <p>5/18/18 - R102 was admitted with a PICC IV line to administer antibiotics.</p> <p>5/18/18 - Physicians' orders for PICC line:</p> <ul style="list-style-type: none"> <li>- Change administration set every 24 hours.</li> <li>- IV administration set reconciliation upon admission: shift change; new infusion or device; and IV related procedure or order change.</li> <li>- Change needleless connector every week and as needed after blood draw or transfusion.</li> <li>- Change non-coring needle every week.</li> <li>- Change catheter site dressing every week.</li> <li>- Change catheter securement device every week.</li> </ul>	F 684			

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F 684	<p>Continued From page 54</p> <p>- Measurement of arm circumference and external catheter length on admission and weekly.</p> <p>5/24/18 - Care plan for IV / PICC line for infection / antibiotic therapy added the approach to change sterile dressing per policy and as needed.</p> <p>May and June, 2018 MAR - Documentation for all above PICC line orders :</p> <p>- All interventions not done on 5/19/18; 5/26/18; and 6/2/18</p> <p>- All interventions done on 5/29/18 and 6/9/18 (arm circumference completed on 5/19/18 but not on 6/9/18)</p> <p>6/14/18 1:15 PM- Interview with E59 (LPN) stated the PICC dressing was done on 6/9/18 and had no further information on why the all the ordered treatments were not done weekly.</p> <p>6/14/18 12:30 PM - Observation of the right arm PICC dressing was dated 6/10/18.</p> <p>These findings were reviewed with E1 (NHA), E2 (DON) and E40 (CRN) during the exit conference on 6/15/18 at approximately 11:30 AM.</p>	F 684		
F 686 SS=D	<p>Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)</p> <p>§483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that-</p> <p>(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition</p>	F 686		7/31/18

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F 686	<p>Continued From page 55</p> <p>demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, clinical record review, interviews, and review of other documentation as indicated, it was determine that the facility failed to provide the necessary care and services to promote healing of pressure ulcers [PU] for three (R28, R33, R102) out of 5 sampled residents with pressure ulcers. R33 and R28 had acquired a new skin impairment and the facility failed to have a system to accurately identify the type of wound, failed to have a competent Wound Care Team to accurately and comprehensively assess the pressure ulcers, and failed to reassess the interventions. For R102 who was at risk for development of a PU, the facility failed to initiate a specialized mattress in a timely manner. Findings include:</p> <p>The facility's policy and procedure titled, Skin Integrity Care Delivery Process, dated 6/1/16, documented the following under the section entitled:</p> <p>- Skin Integrity Impairment Identified: Indicated when a new skin impairment is identified, specific actions will be taken, including a discussion with the physician / mid level provider to obtain and document the probable wound type, wound outcome, and to obtain any needed orders. In addition, a discussion with patient / family to provide education related to type of wound and anticipated/probable outcome (as per the</p>	F 686	<p>1. R28, R33, have been assessed and are receiving appropriate treatment for wound care. R102 no longer resides in the center effective July 3, 2018 with no opportunity to correct.</p> <p>2. Current residents receiving wound care could be affected. The current residents receiving care have been assessed by the physician and treatment orders reflect appropriate care and treatment for their wounds per physician orders.</p> <p>3. Root Cause: Nurses lacked the education to accurately document wound type according to center process despite they were able to provide appropriate recommendations for treatments and interventions. Licensed nursing staff will be educated on or before July 31, 2018 on the Skin Care Delivery Process. New Process: The center has re-assigned the staff responsible for making weekly wound rounds.</p> <p>4. The CNE will review and audit weekly skin sheets for accuracy and completion for 8 weeks, then monthly for 4 months, or until 100% compliance is obtained. The CNE will report to the QAPI committed monthly for further recommendations or</p>		



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F 686	<p>Continued From page 56 provider).</p> <p>- Wound Characteristics Guide: Indicated to review and document correlating characteristics with physician to obtain wound type diagnosis.</p> <p>- Monitoring Outcomes: Indicated monitoring included daily skin inspections during care, weekly skin inspections, as well as by the interdisciplinary wound rounds, which will re-evaluate interventions and treatment plan at least weekly and consider alterations for any patient not responding as per the plan of care, such as no healing progress in two to four weeks.</p> <p>Cross refer F580, Example 1</p> <p>1. Review of R33's clinical record revealed:</p> <p>7/28/16 - Admitted to the facility with Alzheimer's dementia and seizure disorder.</p> <p>7/28/16 (Most recent revision date of 6/5/18) - The care plan initiated for at risk for skin breakdown as evidenced by incontinence included a goal that R33 will not show signs of skin breakdown within the next 90 days with a target date of 6/12/18. Interventions included: Evaluate for any localized skin problem such as dryness, redness; Monitor skin for signs/symptoms of skin breakdown, Norton/Braden assessment per policy; Observe skin condition with ADL care daily and report abnormalities; Pressure redistribution surfaces to bed; Provide pericare/incontinence care as needed; Turn and/or Reposition and check skin every 2 hours or as specified by plan of care, off load heels while in bed.</p> <p>3/16/18 - The quarterly MDS Assessment documented that R33 was severely cognitively impaired for daily decision making, required</p>	F 686	<p>evaluations until resolved and 100% compliance is maintained.</p>		

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F 686	<p>Continued From page 57</p> <p>extensive assistance of one person assist with bed mobility, transfer, dressing, toileting and personal hygiene. In addition, was always incontinent of urine and bowel. Although R33 did not have a PU, R33 was at risk for the development of a PU and interventions included a pressure reducing device for chair and for bed, turning and positioning program, and application of ointments/medications.</p> <p>5/17/18 and timed 3:00 PM - Weekly Skin Check, no skin injury/wound noted.</p> <p>5/24/18 and timed 3:00 PM - Nursing Note, by E27 (LPN), documented a new skin impairment, a PU of the right big toe area measuring 1.0 cm in length (L) x 1.0 cm in width (W) with redness surrounding the area.</p> <p>5/24/18 and timed 10:36 PM - Nursing Note, by E27, documented a change in condition and the managed care organization was notified at 12 midnight on 5/25/18.</p> <p>5/24/18 - Skin Integrity Report (SIR), by E27, documented a new, in-house acquired unstageable PU of the right big toe area. Appearance was intact deep purple, 1.0 cm L x 1.0 cm W x no depth (D).</p> <p>5/24/18 - Physicians' order included to apply Sure Prep [skin treatment] to the area of the skin impairment located on the right big toe every shift.</p> <p>Although the facility had identified this new skin impairment, record review lacked evidence of the facility correlating the characteristics of the wound with the physician to obtain wound type diagnosis.</p>	F 686			

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F 686	<p>Continued From page 58</p> <p>Due to this failure, the facility incorrectly determined the wound type as an unstageable PU instead of a Deep Tissue injury (DTI). In addition, record review lacked evidence that a reassessment of the current interventions including relieving pressure from the affected area.</p> <p>5/25/18 - The facility's Wound Care Team's (WCT's) "Weekly Pressure / Vascular Wounds Measurement" documented a new in-house acquired unstageable PU of right toe measuring 1.0 cm L x 1.0 cm W and D UTD (unable to determine) with intact purple and Sure Prep was the treatment.</p> <p>Although the facility's WCT observed the skin impairment on 5/25/18, the WCT failed to identify and discuss the correlating characteristics with the physician to obtain a wound type diagnosis. The WCT continued to inaccurately identify the wound as an unstageable PU instead of a DTI. In addition, the WCT failed to identify the need to review and revise the current interventions to include relieving pressure from the affected area.</p> <p>5/30/18 - SIR lacked the current stage of the PU. The appearance was intact deep purple, 0.8 cm L X 0.8 cm W and D UTD.</p> <p>5/31/18 - SIR documented unstageable PU with granulation and slough, however, there was lack of evidence of the percentage for each type of tissue. Wound measurement was documented as 1.0 cm L x 1.0 cm W and 0.1 cm depth, with surrounding tissue inflamed. Again, the facility failed to comprehensively assess the PU.</p> <p>5/31/18 - Subsequent WCT's Weekly Pressure /</p>	F 686		

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F 686	<p>Continued From page 59</p> <p>Vascular Wounds Measurement documented 1.0 cm L X 1.0 cm W X D as UTD with granulation and slough.</p> <p>5/31/18 - New treatment order for the wound due to the presence of slough.</p> <p>6/2/18 - SIR documented unstageable PU with 25% necrotic, 50% slough, and 25% granulation with measurement of 1.5 cm L x 2.5 cm W and D UTD, with surrounding tissue inflamed. No information regarding wound edges and no information regarding odor.</p> <p>6/5/18 at approximately 4:00 PM - Assessment of the wound was conducted by E53 (Podiatrist) and E53 concluded that this skin impairment was an arterial ulcer with some component of pressure, thus, plan was to continue with current treatment. Visit note documented an arterial ulcer as well as a stage II ulcer of the right big toe area.</p> <p>6/6/18 at approximately 5:05 PM - An interview with E27 (LPN) who identified the skin impairment on 5/24/18 revealed she called the on-call service but did not recall discussing the type of wound with a physician or a mid-level provider. E27 initiated an order for Sure prep which was applied to the intact skin. Additionally, E27 indicated when she observed the skin impairment on 6/2/18, E27 consulted E28 (RN) who assessed PU and obtained new orders on 6/2/18.</p> <p>6/7/18 at approximately 11:00 AM - An interview with E2 (DON) and E3 (LTC, UM) was conducted. E2 related that the WCT consisted of E2, E3, E4 (TCU, UM), and E10 (RN), however, during WCT's assessment of the skin impairment on 5/25/18 and 5/31/18, E2 was not present. E3 was</p>	F 686		
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F 686	<p>Continued From page 60</p> <p>not present during the 5/25/18 assessment but was present during the 5/31/18 assessment. Both E2 and E3 were asked by the surveyor, if the characteristics documented on the initial SIR dated 5/24/18 correlated with the description of an unstageable PU. Both replied that they did not observe the wound on 5/24/18 and no further response was given.</p> <p>Cross refer F580, Example #2.</p> <p>2. Review of R28's clinical record revealed:</p> <p>4/9/15 - Admitted to the facility.</p> <p>2/16/18 - The Annual MDS Assessment stated R28 had short and long term memory problems, required extensive assistance of two staff for bed mobility, transfer, and was always incontinent of urine. Although R28 did not have a PU, the resident was at risk for the development of a PU and interventions included pressure reducing device for chair and for bed, turning and positioning program, and application of ointments/medications.</p> <p>4/5/15 - (Most recent revision date of 11/22/16) - The care plan initiated for at risk for skin breakdown as evidenced by incontinence, immobility, and history of PU included a goal that R28 will not show signs of skin breakdown within the next 90 days with a target date of 7/4/18. Interventions included: Evaluate for any localized skin problem such as dryness, redness; Monitor skin for signs/symptoms of skin breakdown, skin risk assessment per policy; Observe skin condition with ADL care daily and report abnormalities; Low air loss mattress, and apply barrier cream with each cleansing.</p>	F 686			

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F 686	<p>Continued From page 61</p> <p>6/3/18- SIR documented a new skin impairment, as documented as a Stage II PU of the gluteal cleft with epithelial appearance, 0.5 cm L x 0.5 cm W and 1.4 cm D with no undermining/tunneling and with bloody drainage, no odor, healthy surrounding wound edges and tissue.</p> <p>6/3/18 - New wound care order implemented.</p> <p>Although the facility had identified this new skin impairment, record review lacked evidence of a discussion with the physician or the mid level provider to discuss, obtain and document the probable wound type. In addition, record review lacked evidence a reassessment of the current interventions including relieving pressure from the affected area.</p> <p>6/4/18 - SIR documented documented Stage II PU with characteristics of the wound remained relatively unchanged with dimensions of 1.0 cm L x 1.0 cm W and 1.0 cm D without drainage.</p> <p>6/7/18 - SIR documented a change in the wound type as MASD, however, the characteristics of the wound remained relatively unchanged with dimensions of 1.0 L x 1.5 cm W and 1.0 cm D, no undermining/tunneling, no drainage, surrounding tissue which was inflamed.</p> <p>Record review lacked evidence of a discussion with the physician/mid-level provider to obtain and document probable wound type prior to changing the wound type.</p> <p>6/14/18 at approximately 3:30 PM - An observation of the wound by the surveyor, surveyor supervisor, E2 and E4 was conducted.</p>	F 686			

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F 686	<p>Continued From page 62</p> <p>E4 assessed the wound and verbalized it was a stage II PU and not a MASD.</p> <p>Findings reviewed on 6/15/18, at approximately 11:30 AM with E1 (NHA), E2 (DON), and E40 (CRN).</p> <p>3. The facility's 6/1/16 protocol for skin included the use of a low air loss mattress (LAL) for complicated/multiple full thickness ulcers (Stage 3, Stage 4, DTI, and Unstageable).</p> <p>The following was reviewed in R102's clinical record:</p> <p>5/18/18 - Admitted to the facility.</p> <p>5/18/18 - Admission skin risk assessment indicated R102 was at mild risk for developing a PU. Skin assessment on Admission as follows:</p> <ul style="list-style-type: none"> <li>- Stage 2 sacrum.</li> <li>- DTI right foot.</li> <li>- DTI left heel.</li> <li>- Stage 4 right heel (with a wound vac).</li> <li>- Surgical wound to top of right foot.</li> </ul> <p>5/24/18 - Care plan for Risk for skin breakdown included the intervention for a pressure redistribution surfaces to bed as per protocol.</p> <p>5/25/18 - Admission MDS Assessment documented R102 had one Stage 2 pressure ulcer, one Stage 4 pressure ulcer, and 2 DTIs.</p> <p>6/4/18 - Physicians' orders included a LAL and to check inflation every shift.</p> <p>6/4/18 - NP progress note documented adding LAL for treatment of stage 2 pressure ulcer to sacrum.</p>	F 686	

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F 686	Continued From page 63  6/8/18 9:24 AM - Interview with E43 (CNA) and E44 (LPN) who reported that R102 received the LAL either 6/1 or 6/4/18. Review of the TAR confirmed the LAL was initiated on 6/4/18. The facility failed to initiate the use of an LAL mattress when R102 was admitted on 5/18/18 as per facility protocol when admission assessment revealed multiple pressure areas. These findings were reviewed with E1 (NHA), E2 and E40 (CRN) at the exit conference on 6/15/18 at approximately 11:30 AM.	F 686	
F 689 SS=E	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 record review and observation it was determined that the facility failed to adequately supervise and respond timely to the bed alarm for one (R40) out of 53 sampled residents to minimize accident hazards. In addition the water temperatures in resident bathrooms on one (Homestead unit) out of 3 nursing units was too hot. Findings include:  Cross Refer 656, Example 1. 1. Review of R40's clinical record revealed:  6/27/17 - Admission to facility with multiple	F 689	1. Water temperatures are within the required temperature ranges on all nursing units and managed weekly through the maintenance staff. Staff has been educated on how to report safety concerns through our electronic TELS system. R40 remains in the center and the plan of care has been reviewed and revised with the staff performing care for the resident.  2. Root Cause: Staff did not report any water temperature issues to any



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F 689	<p>Continued From page 64</p> <p>diagnoses including dementia, stroke and vision impairment.</p> <p>6/27/17 - Care plan for ADLs included the intervention to arrange the environment as much as possible to facility ADL performance. It was unclear how the environment was to be arranged for R40, including placement of assistive devices like the walker.</p> <p>7/19/17 - Care plan for falls related to cognitive loss and lack of safety awareness included the goal that the resident would have no falls with injury. Interventions included: provide verbal cues for safety and sequencing when needed; provide resident/caregiver reduction for safe techniques; place call light within reach while in bed or close proximity to the bed; when resident in bed, place all necessary personal items within reach; monitor for and assist toileting needs. On 2/9/18 supervision when out of bed was added. On 4/7/18 bed alarm to alert staff members of resident's need to ambulate at night only. On 5/1/18 the following interventions were added: utilize low bed; maintain a clutter-free environment in resident's room and consistent furniture arrangement.</p> <p>9/8/17 - Care plan for vision impairment included the intervention to arrange R40's environment to enhance vision and maximize independence (i.e., large print signs on dresser, adequate lighting, keep things in same location per patient request/needs).</p> <p>December 2017 - May 2018 - Review of change of condition notes found R40 experienced falls (found on the floor): December 14; February 2, 17, and 22; March 10 and 29; April 6; May 1;</p>	F 689	<p>supervisor as evidenced by TELS systems. R40's individualized care plan interventions were not entered onto the C.N.A. task list to perform. Current residents could be affected. C.N.A. Tasks lists for falls management were reviewed and updated.</p> <p>3. All staff will be trained by the Maintenance director on or before July 31, 2018 on how to access and report any safety concerns on the TELS system.</p> <p>4. The maintenance supervisor will perform weekly rounds to test water temperatures and document the findings. Discrepancies will be reported to the CED. This will be an ongoing process for preventative maintenance to obtain and maintain 100% compliance. The CNE will perform random audits on CNA tasks for fall management in the point of care EMR weekly for 4 weeks, then monthly for 3 months or until 100% compliance is obtained.</p>	

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F 689	Continued From page 65 and June 7.  5/1/18 (2:56 PM) - Nursing note included "Spoke to R40's daughter [first name] and informed her of fall last night. " Daughter believed R40 "intentionally goes to his knees" then "feels his way using the bottom of the bed as a guide." Daughter added that R40's "vision is gone and there is nothing else to be done for him."  5/16/18 - Physical Therapy Discharge Summary documented R40 was discharged from receiving therapy since "maximum potential achieved, referred to RNP/FMP" (Restorative Nursing Program / Functional Maintenance Program).  6/5/18 - Observation at 9:45 AM found R40's in bed and the bed was against the wall with a fall mat on the floor next to the bed along the side open to the room. The room was dark without any lights turned on. The walker was by the bathroom and not near the resident.  6/6/18 (3:42 PM) - Observation of resident lying in bed with the room dark and walker across the room by the bathroom.  6/8/18 (9:34 AM) Observation - Surveyor observed R40 attempting to stand from bed in low position. Room was dark as no lights were turned on. No staff visible in the hallway. Surveyor asked resident to remain seated on the edge of the bed until staff got there to help but R40 refused to stay seated on the side of the bed and wait for staff. Walker not within resident reach (was against wall outside of bathroom on the opposite side of the room of the bed) and R40's wheelchair was in the hallway. Surveyor provided resident with walker, guided resident to the	F 689			

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F 689	<p>Continued From page 66</p> <p>bathroom and turned on the bathroom light. Bed alarm activated as soon as resident stood. R40 stated he wanted to stand to urinate so surveyor guided resident to correct position over toilet. Surveyor stayed with resident to ensure safety until staff responded to the bed alarm. At 9:43 AM E22 (CNA) entered bathroom to see surveyor standing by the resident. E22 got R40's wheelchair from the hallway then assisted R40 into the wheelchair then to back to bed per resident request.</p> <p>The bed alarm rang for 9 minutes before a staff member entered R40's room.</p> <p>During an interview with E5 (Dementia Director) on 6/8/18 at 9:50 AM to describe the aforementioned scenario and the 9 minute response to the bed alarm, E5 responded that sometimes "the alarm is not heard."</p> <p>During an interview with E10 (ADON) on 6/8/18 at 9:55 AM E10 was informed about the 9 minute response time to the activated bed alarm and offered no information.</p> <p>During an interview with E42 (PT) on 6/8/18 at 10:30 AM to review R40's progress and discharge goals from the service ending 5/16/18, E42 stated that R40 was "independent with ambulation using the walker" but the resident's "right foot would start dragging" after R40 walked a longer distance like 50 feet. The expectation was for R40 to continue to walk independently. E42 stated that bright color tape was attached to the walker to aid R40 in seeing it due to visual impairment.</p> <p>6/9/18 (6:25 PM) - Observation of R40 in bed on</p>	F 689		

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F 689	<p>Continued From page 67</p> <p>back with eyes closed. Bed low but not all the way down, fall mat next to the bed, walker across the room. Lights were off.</p> <p>The facility was not following the plan of care to prevent accidents as R40's walker (a necessary personal item) was not in reach nor was there adequate lighting in the resident's room to see the walker.</p> <p>2. Observation of water temperatures on the Homestead (Memory Support) unit revealed hot water in resident room bathrooms were too hot:</p> <p>6/5/18 (9:40 AM - 9:56 AM) - Observation during room assessments found water in the bathroom sinks of several rooms (one on each end of the long hallway and a room on the short hallway) felt hot to the touch and would need to be verified with a thermometer: Rooms 305, 309 and 312.</p> <p>During an observational interview with E5 (Dementia Director) on 6/5/18 between 10:23 AM - 10:40 AM water temperatures were confirmed.</p> <ul style="list-style-type: none"> <li>- Room 305: 115.3 F</li> <li>- Room 309: 115.8 F</li> <li>- Room 314: 126.2 F</li> </ul> <p>During an interview with E17 (CNA) on 6/5/18 at 10:26 AM about the water temperature, E17 stated that "staff complained" over the past month about the "water being too hot and nothing was done."</p> <p>During an interview with E23 (Maintenance Supervisor) on 6/5/18 at 10:29 AM to discuss the hot water temperatures, E23 said s/he would adjust the hot water heaters for that unit.</p>	F 689			

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F 689	<p>Continued From page 68</p> <p>6/5/18 (12:20 PM - 12:30 PM) - Observed acceptable hot water temperatures:</p> <ul style="list-style-type: none"> <li>- Room 314: 113.3 F</li> <li>- Room 312: 112.6 F</li> <li>- Room 305: 112.8 F</li> <li>- Room 309: 112.1 F</li> </ul> <p>6/5/18 at approximately 2:10 PM - E1 (NHA) was informed of the hot water concern on Homestead unit and the subsequent adjustment of the water heaters.</p> <p>6/5/18 (3:40 PM - 3:50 PM) - Observed water temperatures found to be too hot:</p> <ul style="list-style-type: none"> <li>- Room 305: 116.7 F</li> <li>- Room 309: 118 F</li> <li>- Room 312: 116.4 F</li> <li>- Room 314: 118 F</li> </ul> <p>During an interview with E5 and E10 (RN) on 6/5/18 at 3:52 PM, the increasing hot water temperatures were reviewed and E10 paged E23.</p> <p>During an observational interview with E23 on 6/5/18 at 4:04 PM the water temperature in room 317 on the short hallway was confirmed at 117.5 F with both the facility and surveyor thermometer. At 4:06 PM the surveyor observed E23 reducing the thermostat on the two hot water heaters and E23 stating it was "low as it can go."</p> <p>6/6/18 (8:10 AM - 8:24 AM) - Observed hot water temperatures:</p> <ul style="list-style-type: none"> <li>- Room 305: 104.7 F</li> <li>- Room 309: 105.8 F</li> <li>- Room 311: 105.6 F</li> <li>- Room 314: 105.9 F</li> </ul> <p>During an interview with E5 on 6/6/18 at 8:25 AM</p>	F 689		

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F 689	Continued From page 69 the acceptable hot water temperature readings ere reviewed.  6/6/18 at 3:10 PM - Surveyor overhead E57 (CNA arriving for next shift) ask E17 about the hot water. E17 responded the water was good since "the surveyor took care of it."  These findings were reviewed with E1, E2 (DON) and E40 (CRN) at the exit conference on 6/15/18 at approximately 11:30 AM.	F 689			
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3)  §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.  §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to	F 690		7/31/18	

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F 690	<p>Continued From page 70</p> <p>prevent urinary tract infections and to restore continence to the extent possible.</p> <p>§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview it was determined that the facility failed to ensure services and assistance to maintain urinary continence and/or provide interventions to minimize the chance of a resident with an indwelling urinary catheter from getting an infection for three (R35, R86 and 102) out of 53 sampled residents. Findings include:</p> <p>1. Review of R35's clinical record revealed:</p> <p>2/15/16 - Admission to the facility with multiple diagnoses including Parkinson's Disease and dementia.</p> <p>2/7/17 - Care plan for Incontinent of urine with the potential for improved control or management of urinary elimination with the goal for improved urinary elimination control by experiencing less episodes of urinary incontinence. Interventions included: complete a voiding diary and evaluate for patterns of incontinence at appropriate intervals; complete an incontinence assessment at intervals according to policy and procedure; prompted toileting every 2 hours while awake 7:00 AM - 3:00 PM, 3:00 PM - 11:00 PM shift; alert nurse of any refusals. 11:00 PM - 7:00 AM</p>	F 690	<p>1. R35 has been re-assessed and a significant change MDS was completed on 6/15/2018. R86 catheter tubing has been placed into a dignity bag, preventing catheter tubing from touching the floor and the staff providing care has been made aware. R102 currently does not reside in the center as of 7/3/2018, center has no ability to correct. Catheter care has been added to the task list for C.N.A. documentation.</p> <p>2. There are 8 current residents receiving catheter care that could be affected. These current residents have been assessed for continence status and catheter tube placement and the MDS has been reviewed to confirm or updated the MDS to reflect the current residents' status.</p> <p>3. Root Cause: E43(C.N.A.) failed to perform appropriate catheter care. On or before July 31, 2018, the Unit managers and ADON will educate the C.N.A's on center's Care of Indwelling Catheter Care to include documentation of continence</p>	

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F 690	<p>Continued From page 71 toilet at midnight and 5:00 AM.</p> <p>12/22/17 - Annual MDS Assessment documented R35 was occasionally incontinent of urine and was independent with transfer and toileting.</p> <p>3/16/18 - Quarterly MDS Assessment recorded R35 was now frequently incontinent of urine, requiring extensive assistance with transfer and toileting.</p> <p>Review of the record found no evidence of a voiding diary or incontinence assessment after the decline of urinary continence.</p> <p>During an interview with E18 (RNAC) on 6/8/18 at 10:09 AM E18 confirmed that the decline of urinary continence had not been identified in March, 2018.</p> <p>September, 2017 - May, 2018 - Review of CNA documentation found R35's percentage of bladder continence fluctuated but the degree of incontinence increased from 27.8% in September, 2017 to 54.8% in February, 2018 and 50.5% in March, 2018.</p> <ul style="list-style-type: none"> <li>- September, 2017: 27.8% (25 out of 90 shifts).</li> <li>- October, 2017: 46.2% (43 out of 93 shifts).</li> <li>- November, 2017: 36.7% (33 out of 90 shifts).</li> <li>- December, 2017: 32.2% (29 out of 90 shifts), excluded 3 shifts when on a leave of absence.</li> <li>- January 18 45.2% (42 out of 93 shifts).</li> <li>- Feb 18 54.8% (46 out of 84 shifts).</li> <li>- Mar 18 50.5% (47 out of 93 shifts).</li> <li>- Apr 18 35.6% (32 out of 90 shifts).</li> <li>- May 18 35.5% (33 out of 93 shifts).</li> </ul> <p>The facility failed to identify an increase in urinary incontinence (decline of urinary continence) for</p>	F 690	<p>status and catheter care.</p> <p>4. The Unit managers and ADON will preform daily audits and observations for 2 weeks, then weekly for 4 weeks, then monthly for 2 months to observe catheter care is provided and documented until 100% compliance is achieved. The ADON will report finding to the QAPI committee monthly for further recommendations and evaluation until 100% resolved.</p>	



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F 690	<p>Continued From page 72</p> <p>R35 and did not complete a voiding diary and incontinence assessment to determine interventions to improve or maintain R35's urinary continence. R35's urinary continence improved in April and May, 2018 in spite of the lack of assessment or intervention by the facility.</p> <p>During an interview with E10 (ADON) and E5 (Dementia Director) on 6/8/18 at 10:50 AM the surveyor described the change of urinary incontinence from occasional to frequent was not identified in March 2018. No explanation or additional information was provided.</p> <p>2. Review of R86's clinical record revealed:</p> <p>6/1/96 - Facility policy entitled Care of Indwelling Urinary Catheter (last revised 1/2/14) included to "secure catheter tubing to keep the drainage bag below the level of the patient's bladder and off the floor."</p> <p>4/23/18 - R86 admitted to the facility with a suprapubic catheter through the lower abdomen to drain urine from the bladder.</p> <p>4/30/18 - Care plan problem for indwelling catheter due to urinary retention . . . included the intervention to keep catheter off floor.</p> <p>Observations of R86's urinary catheter tubing touching the floor, increasing the chance of developing an infection:</p> <p>- 6/4/18 (2:00 PM) - R86 seated in a wheelchair at a table in the activity room with the urinary catheter tubing visible below the pant leg and laying on the floor and positioned where, if the wheelchair would be pulled backwards to take the resident away from the table, the front wheel</p>	F 690		

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F 690	<p>Continued From page 73</p> <p>would run over the tubing located laying on the floor behind the wheel.</p> <p>- 6/7/18 (1:41 PM) - Resident seated in the wheelchair with urinary tubing dragging on the floor when R86 was self-propelling.</p> <p>The facility failed to keep R86's indwelling catheter tubing off the floor when the resident was seated in the wheelchair.</p> <p>3. The following was reviewed in R102's clinical record:</p> <p>Facility policy for Catheter Care (last revised 1/2/14) included that catheter care should be provided twice a day and as needed:</p> <ul style="list-style-type: none"> <li>- Wash perineal area with no-rinse perineal cleanser; pat dry.</li> <li>- Male: Wash area around catheter insertion site and then wash from the tip of the penis down to the body. Include the scrotum and skin folds around and underneath the scrotum. If male is uncircumcised, the foreskin must be retracted and cleaned. Return the foreskin to its original position once penis dry.</li> <li>- Cleanse the proximal third of the catheter with soap and water, washing away from the insertion site and manipulating the catheter as little as possible. Rinse.</li> </ul> <p>Review of R102's individual CNA task list discovered that catheter care was not included.</p> <p>6/14/18 9:13 AM - Observation of E43 (CNA) performing indwelling cath care for R102 observed the following:</p> <ul style="list-style-type: none"> <li>- Did not use perineal wash to cleanse perineal area first.</li> <li>- Washed bowel movement (BM) in groin folds by wiping back to front and front to back instead of</li> </ul>	F 690			

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F 690	Continued From page 74 front to back (from clean area toward dirty area). - Washed penis by wiping up and down from body instead of down the body by starting at the catheter and moving down the penis. - Cleansed the catheter away from body correctly with a clean wash cloth but used contaminated water since the water in the basin was not changed after cleaning of the BM. - Dried the resident with a towel after cleaning up BM, then used the same contaminated towel to dry the penis / catheter.  6/14/18 2:14 PM - Interview with E43 revealed the CNA had been employed by the facility for around a year and was only educated in catheter care during orientation. E43 confirmed catheter care was not on R102's individualized CNA task list in the EMR.  There was no evidence that R102 received catheter care twice a day and PRN since catheter care was not included on R102's individualized CNA task list. In addition, poor technique was used as water and textiles were used for catheter care after being contaminated with BM.  Findings reviewed on 6/15/18, at approximately 11:30 AM with E1 (NHA), E2 (DON), and E40 (CRN).	F 690			
F 710 SS=E	Resident's Care Supervised by a Physician CFR(s): 483.30(a)(1)(2)  §483.30 Physician Services A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. A physician, physician assistant, nurse practitioner, or clinical nurse	F 710		7/31/18	

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F 710	<p>Continued From page 75</p> <p>specialist must provide orders for the resident's immediate care and needs.</p> <p>§483.30(a) Physician Supervision. The facility must ensure that-</p> <p>§483.30(a)(1) The medical care of each resident is supervised by a physician;</p> <p>§483.30(a)(2) Another physician supervises the medical care of residents when their attending physician is unavailable. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to ensure the physician supervised the medical care, specifically medical issues related to the resident's skin status, for two (R29 and R102) out of 53 sampled residents. Findings include:</p> <p>1. Review of R29's clinical record revealed: 8/17/17 - R29 admitted to facility after hospitalization for a non-displaced rib fracture after a fall at home. 8/17/17 - Admission nursing assessment documented R29's buttocks were red, but blanchable and was at risk for developing a PU. Moisture Associated Skin Damage to buttocks, groin and sacrum identified on skin check by nursing. 8/24/17 - Admission MDS Assessment indicated R29 was cognitively intact but required extensive assistance of two persons for bed mobility, transfer and toilet use. The resident was always incontinent of bowel and occasionally incontinent</p>	F 710	<p>1. R29 is receiving treatment and services for wound care with physician observation of the wound care as necessary. R102 no longer resides in the center as of July 3, 2018 with no ability for the center to correct.</p> <p>2. There are 12 current residents receiving wound care treatment that could be affected. Each resident has been assessed for wound care and treatment by the physician.</p> <p>3. Root Cause: Physician's do not perform routine wound observations unless requested by the nursing staff. NEW PROCESS: The MD/NP will observe a residents wound at least bi-monthly or more frequent for complex wound care and at the request of the wound care team and document their observation/findings.</p> <p>4. The CNE will perform weekly audits for 4 weeks, then monthly for 2 months of the</p>		

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F 710	<p>Continued From page 76</p> <p>of urine but did not have a PU on admission, but was at risk for developing a PU.</p> <p>December, 2017 - May, 2018 - Although R29 was frequently evaluated by E41 (Physician), under the Physical Exam section under "skin", E41 consistently wrote "see nursing wound care assessment" on the following dates: December 19, 21, 27; January 12, and 25; February 14 and 28; April 5; and May 18.</p> <p>5/31/18 2:15 PM - Interview with R29 with investigator from Delaware Health Care Quality revealed extensive reddened area over right buttock measuring 27 cm x 35 cm with open ulceration area with possible eschar, measuring 2 cm x 1.5 cm x 0.1 cm. Examination of the abdominal fold showed area of redness, measuring 12 cm x 18 cm. Examination of left buttock revealed a 3.5 cm circular area as well as dark red discoloration on R29's back, buttocks and bilateral legs. E3 (RN) stated that R29 had Moisture Associated Skin Damage, which was present upon admission to facility. Blood noted on drawsheet (in trash) with wound care.</p> <p>6/1/18 approximately 2:05 PM - Interview with E41, who stated s/he would go in for "acute complaints" and relied on information relayed from nursing. The physician stated the last time s/he saw R29's wound area was approximately two months prior and the resident had no open areas at that time. E41 acknowledged that the rash in the groin and abdominal areas had been a "frequent issue" and that the physician previously directed R29 to keep the area dry and clean. E41 added that staff had issues in the past with R29 refusing to shower and would evaluate R29 early the following week.</p>	F 710	<p>physician's notes to determine evidence that the MD/NP is supervising the care provided on residents skin until 100% compliance is obtained. The CNE will report findings to the Medical Director weekly for 4 weeks, then monthly for 2 months, for further recommendations and evaluations.</p>	

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F 710	<p>Continued From page 77</p> <p>6/4/18 3:39 PM - E41 examined R29 with the surveyor and found small amount of bleeding with red / pink wound bed. E41 explained to R29 that in order to promote healing, a dry environment must be created and maintained. This included keeping the area clean and dry, using medicated powder for abdominal folds and need for repositioning. E41 also explained that pressure and weight will cause moisture.</p> <p>The physician failed to supervise and assess R29's pressure ulcer.</p> <p>Findings were reviewed with E1 (NHA), E2 (DON), E40 (Corporate Regional RN) at the exit conference on 6/15/18, which started at 11:45 AM.</p> <p>2. The following was reviewed in R102's clinical record:</p> <p>5/18/18 - Admitted to facility without documentation of penile pressure ulcer.</p> <p>6/3/18 9:42 PM - Progress note documented R102 had a sore at the tip of the penis at the catheter site. Patient had scant amount of bleeding at the tip of the penis.</p> <p>6/3/18 - Physicians' orders included to monitor tip of penis for signs and symptoms of infection and worsening of size every shift. Alternate catheter leg securement device from left to right leg daily.</p> <p>6/4/18 - 6/13/18 - Review of progress notes by E58 (NP) lacked assessment or documentation of the penile ulceration.</p> <p>6/7/18 10:30 AM - Interview with E2 (DON) and</p>	F 710		

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F 710	Continued From page 78 E4 (UM-RN) revealed the medical practitioner would try to visualize the wound(s) on a weekly basis but sometimes it was two weeks.  6/14/18 11:59 AM - Interview with E58 about the sore on the penis revealed E58 was only told by staff that it was just a tiny open area and that s/he had not actually visualized it. E58 and the surveyor observed the wound together, she stated the area was related to pressure from the catheter.  This finding was reviewed with E1 (NHA), E2 and E40 (CRN) on 6/15/18 at approximately 11:30 AM.	F 710			
F 725 SS=F	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2)  §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).  §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and	F 725		7/31/18	

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F 725	<p>Continued From page 79</p> <p>(ii) Other nursing personnel, including but not limited to nurse aides.</p> <p>§483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and review of other facility documentation it was determined that the facility failed to have sufficient nursing staff to provide care to ensure all residents received needed care and services. Findings include:</p> <p>1. Interviews performed on 6/4/18 and 6/5/18 with 12 (A [anonymous] 5, A8, A9, A11, A12, A13, A14, A15, A16, A17, A18, and A19) residents, who desire to remain anonymous, stated they experienced long wait times for care especially on evening and night shifts, and all shifts on weekends; one resident described an incontinent episode due to the long wait; care not consistently performed including, ambulation and showers.</p> <p>Cross Refer F565</p> <p>2. Review of past 6 months of Resident Council Meeting minutes revealed staffing concerns discussed at every monthly meeting:</p> <p>12/6/17 - Old / Unfinished business: Hiring new CNAs.</p> <p>- Nursing complaints: need better CNAs on day shift, short staffed on 11:00 PM -7:00 AM.</p> <p>- Facility's response: none.</p> <p>1/3/18 - Nursing complaints: several residents stated they have untimely wait times from when they rang the call bell until their call bell was</p>	F 725	<p>1. Staffing schedules and concerns are addressed daily for call light response and to meet or exceed the necessary State and Federal requirements.</p> <p>2. Any current resident could be affected.</p> <p>3. Root Cause: Center is challenged with staff call outs and employee turnover. Center continues to recruit staff daily and perform frequent new hire orientation to facilitate an effective hiring process. Center continues to address performance issues with current staff for attendance and resident care. Center is participating in a new C.N.A. training program to increase labor force.</p> <p>4. CED will continue to monitor daily staffing and replace staff who call out timely. CED will continue to aggressively recruit new staff and retain current staff. CED will meet monthly with the resident council and respond in writing to all of there concerns. This will be an ongoing process. Retention and turnover data will be reviewed monthly by the CED and nurse leaders. Retention and turnover data will be submitted to the QAPI committee monthly for further</p>	



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F 725	<p>Continued From page 80</p> <p>answered. Resident stated s/he waited twenty minutes until the call bell was answered. Resident stated, mostly on 11 PM -and 7 AM shift, the wait had been 30 minutes before someone answered the call bell. Several residents stated that CNAs told them they cannot take care of them because the CNA was not assigned to the resident and needed to wait for their assigned CNA for assistance. - Facility's response: none.</p> <p>2/7/18 - Nursing complaints: Staff shortages and some work ethic concerns. E2 (DON) attended and discussed staffing issues for CNAs and nurses, and addressed residents' concerns. - Facility's response: Facility has engaged in corporate programs to facilitate recruitment and has hired 4 nurses and 5 CNAs in past week.</p> <p>3-7-18 - Nursing complaints: Residents stated there still is not enough CNAs or nurses and had to wait a long while for their call lights to be answered. - Facility's response: none.</p> <p>4/11/18 - Old / Unfinished business: staffing issues and hiring of new staff. - Nursing complaints: CNAs short staffed. CNAs do not stay and agency nurses do not know residents. - Facility's response: none.</p> <p>5/10/18 - Nursing complaints: new nurses having to ask other nurses for assistance at night but nurses not available at night to answer questions; not receiving all our medications; not enough staff. - Facility's response: Will review with nursing staff resident concerns of medications. Working</p>	F 725	recommendations and evaluation.	

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F 725	<p>Continued From page 81 on hiring for the 3:00 PM - 11:00 PM and 11:00 PM - 7:00 AM shifts.</p> <p>6/4/18 - Prior meeting minutes reviewed: nursing concerns. - Old / Unfinished business: Facility staff stated nurse staffing being resolved with new hires, job postings.</p> <p>6/8/18 12:45 PM - 2:00 PM - Resident Meeting with the surveyor, ombudsman and seven residents. In response to the questions "Do you get the help and care you need without waiting a long time? Does staff respond to your call light timely?" Multiple residents stated "no". - A[anonymous]1: "Waited an hour for call bell to be answered" and then they told me they will be back. Then it was "another hour before they came back" to help me. - A2: Staff "turned call bell off at the nursing station without answering or helping me." - A3: They do not have enough staff to feed all the residents that need to be fed, which takes away from the rest of us who may need a little help. - A3: They do not have enough staff to get people out of bed. They let people lay in bed all day, and some people are not gotten up until 3:00 PM and then are put them back in bed quickly. - A5: Wait for call lights to be answered from 30 minutes to an hour. All the good staff have quit or are quitting. Most of the new staff they hire quit before long. - A7: I came out of shower room one night and 4 call bells were going off ringing. There was a CNA just standing in hall and would not answer any of the call bells. I said something to the CNA who said, "not my job - they are not assigned to me." - A7: I waited 15 minutes on Sunday for help</p>	F 725		

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F 725	Continued From page 82 after I rung my call bell. Lack of staff leads to long waits for call bells to be answered.  During an interview on 6/15/18 at 10:21 AM, E1 (NHA) explained that scheduling staff had been an issue. E1 also pointed out that audits performed to correct staffing concerns cited during last year's survey were no longer being performed.  Findings reviewed on 6/15/18, at approximately 11:30 AM with E1, E2, and E40 (CRN) during the exit conference.	F 725			
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4)  §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census.  §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format.	F 732		7/31/18	

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F 732	Continued From page 83 (B) In a prominent place readily accessible to residents and visitors.  §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.  §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility failed to post the required nurse staffing information. Findings include:  An observation was made on 6/14/18 at 10:55 AM of Nursing Station 1 and Nursing Station 2. The only staffing sheets posted did not include facility name, hours worked by nursing staff and resident census.  During an interview on 6/14/18 at 11:07 AM, E1 (NHA) stated the observed postings hanging on the corner of each hall were the facility's staffing information and were changed each shift. E1 also confirmed that all required information was not on postings.  Findings reviewed on 6/15/18, at approximately 11:30 AM with E1, E2 (DON), and E40 (CRN) at the exit conference.	F 732	1. Center has revised its staffing posting to include the necessary requirements.  2. Current resident could be affected.  3. The HR manager has been educated to the staffing posting requirements by the CED. The CNE and or designee will make daily rounds to observe compliance.  4. The CNE and or designee will make daily rounds to observe correct postings are readily available and accessible for the next 4 weeks or until 100% compliance is obtained.		
F 745	Provision of Medically Related Social Service	F 745		7/31/18	

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F 745 SS=D	Continued From page 84 CFR(s): 483.40(d)  §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview it was determined that for one (R97) out of 53 sampled residents the facility failed to provide medically related social services to assist a resident to replace a partial denture unable to be repaired. Findings include:  1. The following was reviewed in R97's clinical record:  11/7/12 - Care plan for exhibits or is at risk for oral health or dental care problems (last reviewed 3/31/18) as evidenced by broken, loose and carious teeth and not wearing partial plate dentures. Approaches included encourage resident to wear dentures.  3/22/18 - Dentist examination note documented "partial upper denture in cup, unable to use after natural teeth broke off... partial denture cannot be repaired for use."  5/11/18 - Quarterly MDS Assessment documented R97 was moderately cognitively impaired and had no broken or loose fitting full or partial denture (chipped, cracked, uncleanable or loose).  6/13/18 around 9:15 AM - Interveiw with E11 (LPN) and E10 (RN) about the partial denture and dental consult revealed that they were unaware of	F 745	1. R97 has been assessed by the dentist and staff are aware of the plan of care.  2. Current residents needing dental care could be affected. Current residents have been assessed by nursing for dental care and potential treatment plans or referrals needed to the dentist.  3. ROOT CAUSE: One dental consult was not shared with the nursing staff for clear and documented plan of care. NEW PROCESS: Dental consults will be reviewed at each clinical morning meeting to determine any follow up care that needs to be coordinated or care planned.  4. The CNE will perform weekly dental consult audits for 4 weeks, then monthly for 2 months or until 100% compliance is obtained. The CNE will report findings to the QAPI committee monthly for further recommendation or evaluation until 100% compliance is obtained.		

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F 745	Continued From page 85 the issue and that social services handled dental issues.  6/13/18 9:30 AM - Interview with R97 revealed that s/he could not wear the partial denture and the resident would like a new one. R97 demonstrated to the surveyor that the partial denture would no longer stay in his/her mouth.  6/13/18 9:45 AM - Interview with E7 (SW) and E8 (SW) revealed that they did not know anything about R97's dentures but E7 would put a call in to the dentist to see what they could find out. It was confirmed that R97 had Medicaid insurance and would be eligible for protected funds if denture replacement was needed.	F 745			
F 756 SS=D	Findings reviewed on 6/15/18, at approximately 11:30 AM with E1 (NHA), E2 (DON), and E40 (Regional Nurse) during the exit conference. 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.	F 756		7/31/18	

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F 756	<p>Continued From page 86</p> <p>(ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.</p> <p>(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.</p> <p>§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:</p> <p>Based on record review and interview it was determined that the facility failed to conduct one monthly medication review and failed to ensure a recommendation by the pharmacy consultant was reviewed and acted upon by the physician for one (R2) out of 5 sampled residents reviewed for medication review. Findings include:</p> <p>1. Review of R2's clinical records revealed the following:</p> <p>4/6/18 - R2 readmitted to the facility from the hospital.</p> <p>Record review lacked evidence of Monthly</p>	F 756	<p>1. R2 pharmacy recommendations have been responded to by the physician.</p> <p>2. Current residents could be affected.</p> <p>3. Root Cause: Consultant pharmacist colleague (covering for vacation) was unaware that the center did not pull reports electronically and therefore did not forward the April report to the center. CNE has been educated to where to locate electronic copy of report when center has an interim consultant.</p> <p>4. CNE will review pharmacy</p>	

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F 756	Continued From page 87 Medication Review for April 2018.  6/13/18 at approximately 3:00 PM - An interview with E35 (Consultant Pharmacist) revealed that an irregularity was identified on 4/11/18 by his colleague, E36 (Consultant Pharmacist). E35 verbalized that s/he would forward the irregularity report to E1 (NHA). Shortly after this interview, E1 informed the surveyor that E1 did receive the information and subsequently, forwarded to E2 (DON). E2 indicated she was not aware of this irregularity until today, 6/13/18, thus, not acted upon.  Findings were reviewed with E1, E2 and E40 (CRN) on 6/15/18 at approximately 11:30 AM during the exit conference.	F 756	recommendations reports monthly for 4 months to determine they have been received or obtained by the center. This will be an ongoing process until 100% compliance is obtained. CNE will report findings to the QAPI committee monthly for further recommendations and evaluation to maintain compliance.		
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	F 758		7/31/18	



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F 758	<p>Continued From page 88 in the clinical record;</p> <p>§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;</p> <p>§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</p> <p>§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.</p> <p>§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 record review and interview it was determined that out of 5 sampled residents for medication review: one (R75) resident received an antipsychotic medications without adequate indication for use and without adequate monitoring; one (R2) resident had a PRN order for psychotropic medication longer than 14 days without attending physician documentation. Findings include:</p>	F 758	<p>1. R75 medications has been reviewed and resident has been re-assessed for hallucinations and delusions. The resident continues to be followed by mental health provider with supporting documentation by provider and staff. R2 medications has been reviewed and is receiving medications as ordered.</p>	

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F 758	Continued From page 89  1. The following was reviewed in R75's clinical record:  R75 had diagnoses which included dementia, anxiety, depression and agitation.  5/17/17 - Care plan for at risk for complications related to the use of psychotropic drugs medication: antidepressant, antianxiety. Approaches included; complete behavior monitoring flow sheet; monitor for continued need for medication as related to behavior and mood.  10/31/18 - Care plan for disruptive demanding behaviors as evidenced by demanding immediate attention even if you are with another resident (repeatedly requesting to toilet even after toileting done - most often no results).  February 2018 Behavior Monitoring with number of episodes: anxiety - 0 agitation - 0 crying - 0 meds listed: 2 medications each for anxiety and depression  2/5/18 - Care plan for disruptive demanding behavior as evidenced by repetitive calling out "help me" even when staff had helped resident.  March 2018 Behavior Monitoring with number of episodes: anxiety - 4 agitation - 1 crying - 1 meds listed: 2 medications each for anxiety and depression	F 758	2. Current residents on Psychotropic medications or with new orders for psychotropic medications could be affected. Current residents on psychotropics were reviewed and evaluated for necessary treatment of conditions.  3. Root Cause: For R75 staff (E56) NP did not document according to center expectations. E56 has been informed of center expectations for documentation/rationale of new orders for psychotropic medications. For R2, center PRN orders from hospital were not reviewed for length of treatment upon admission. New Process: Center will review psychotropic medications orders upon admission, re-admission, and PRN as written at each daily clinical meeting.  4. CNE and nurse managers will review new and re-admitted residents PRN medications at each clinical meeting for 4 weeks, then monthly for 2 months or until 100% compliance is obtained. The CNE will report to the QAPI committee monthly for further recommendations or evaluations until 100% compliance is obtained.		

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F 758	Continued From page 90  3/1/18 - Care plan for exhibits or is at risk for distressed/fluctuating mood symptoms related to recent changes affecting functional loss.  3/1/18 - Assessment "since the last evaluation, behavior symptoms have decreased, demanding immediate attention, repetitive call for help with no needs, none noted, no pharmacological interventions attempted, in the last 30 days attempt to redirect and divert, calm..."  3/14/18 3:39 PM - Progress note "[name of mental health provide] evaluation for increased delusions and paranoia..."  3/19/18 - Provider note ... referral made to [name of mental health provider] last week due to increasing delusions and hallucinations per staff and daughter. Monitor mood and behaviors ... psychotic disorder with delusions due to known physiological condition ... was receiving {name of antipsychotic medication} ... but was discontinued and resident is tolerating well. Per daughter and staff delusions present now ...  There was no evidence that behavior monitoring for delusions and hallucinations was being conducted.  3/21/18 - Quarterly MDS Assessment documented diagnoses of dementia, anxiety and depression.  3/21/18 - New physician's order for [name of antipsychotic medication] for paranoid delusions.  Mental health provider visits included: 3/22/18 - recommend to increase medication for	F 758			

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F 758	<p>Continued From page 91</p> <p>anxiety. 3/26/18 - positive paranoid delusions and hallucinations. 4/9/18 - no antipsychotic listed on assessment. 4/30/18 - no antipsychotic listed on assessment.</p> <p>April, 2018 and May, 2018 Behavior Monitoring with number of episodes: anxiety - 0 agitation - 0 crying - 0 meds listed: 2 medications each for anxiety and depression, 1 antipsychotic for paranoid delusions Antipsychotic not included for side effect monitoring.</p> <p>5/1/18 - Quarterly MDS Assessment documented diagnoses of dementia, anxiety and depression.</p> <p>June 2018 Behavior Monitoring with number of episodes: anxiety -0 agitation - 0 crying - 0 meds listed: 2 medications each for anxiety and depression, 1 antipsychotic for paranoid delusions Antipsychotic not included for side effect monitoring.</p> <p>6/12/18 2:30 PM - Interview with E12 (CNA) revealed R75 had no changes in behaviors.</p> <p>6/12/18 2:36 PM - Interview with E22 (CNA) no changes in behavior. R75 was always anxious, requested to go to bathroom a lot. When asked about paranoia and delusions E22 stated that resident requested to go to the bathroom and</p>	F 758		
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F 758	<p>Continued From page 92</p> <p>said s/he can't find his/her rings. E22 added that R75 had to have "everything just right" and in the "right order," like her make-up and creams. You have to keep her routine."</p> <p>6/13/18 8:57 AM - Interview E11 (LPN) revealed R75 was very anxious. When asked about paranoia and delusions E11 said not on day shift. E11 added that the resident asks to go to the bathroom a lot and gets anxious when waiting for the hairdresser.</p> <p>6/13/18 9:18 AM - Interview with E10 (RN) and E5 (Dementia Director) about use of the antipsychotic medication and lack of monitoring before and after the medication was started revealed no further information.</p> <p>6/13/18 9:42 AM - Interview with E7 (SW) and E8 (SW) revealed they had no knowledge of the reason or the use of the antipsychotic or the behaviors associated with it.</p> <p>6/14/18 11:21 AM - Interview with E9 (NP) revealed s/he visited the facility twice a week and talked to the nurses and aides about the residents. In March 2018 E9 was told that R75 would push at the unit door and say her husband was there and thought R75 was seeing her husband E9 added that staff also said that R75 was seeing things on the wall that were not there. When asked about documenting behaviors and non-pharmological approaches E9 stated that staff were supposed to document but "I can't make them." E9 agreed that it was important to know what behavior / symptoms the medication was being used for and to document the frequency of the behavior. E9 stated that from talking to staff it was determined the resident was</p>	F 758			

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F 758	<p>Continued From page 93</p> <p>having paranoia and delusions so the antipsychotic was prescribed. E9 confirmed that the medication was ordered the first time seeing the resident and that s/he did not document what staff told him.</p> <p>Findings reviewed on 6/15/18, at approximately 11:30 AM with E1 (NHA), E2 (DON), and E40 (CRN) during exit conference.</p> <p>2. Review of R2's clinical records revealed the following:</p> <p>4/6/18 - R2 readmitted to the facility from the hospital.</p> <p>4/6/18 - An admission order for an anti-anxiety medication to be given three times a day PRN for anxiety.</p> <p>4/6/18 - 4/30/18 - Review of MAR revealed no use of this medication.</p> <p>Record review lacked evidence of the attending physician or prescribing practitioner's reason for the appropriate use of the PRN to be extended beyond 14 days which was 4/20/18.</p> <p>May, 2018 and June, 2018 - Monthly Physician's Order continued to include the above PRN antianxiety order.</p> <p>May, 2018 - June 2018 - MAR revealed no use of this medication through 6/13/18.</p> <p>Again, record review lacked evidence of the attending physician or prescribing practitioner's reason for the appropriate use of the PRN to be extended beyond 4/20/18 (14 days from order).</p>	F 758		

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F 758	Continued From page 94 6/13/18 at approximately 12:15 PM - An interview with E56 (NP) revealed that s/he had not reassessed the order for the PRN antianxiety medication, however, would conduct the reassessment.	F 758			
F 802 SS=E	Findings reviewed on 6/15/18, at approximately 11:30 AM with E1 (NHA), E2 (DON), and E40 (CRN) during the exit conference. Sufficient Dietary Support Personnel CFR(s): 483.60(a)(3)(b)  §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).  §483.60(a)(3) Support staff. The facility must provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service.  §483.60(b) A member of the Food and Nutrition Services staff must participate on the interdisciplinary team as required in § 483.21(b) (2)(ii). This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interviews, it was determined that the facility failed to employ sufficient support personnel to safely and effectively carry out the functions of the food and nutrition services. Findings include:	F 802	1. The dining room has remained opened for service.  2. Current residents could be affected.	7/31/18	

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F 802	Continued From page 95  Cross refer, F565 Example #1. On 6/9/18 at approximately 5:05 PM, an interview with E3 (LTC UM), revealed that the Main Dining Room (MDR) was closed for the dinner meal and residents would be consuming their meals in their rooms.  An interview with E37 (Chef ) on 6/10/18, at approximately 7:10 PM revealed, the MDR was closed for dinner was due to shortage of food and nutrition services support staff.  An interview with E31 (Dietary Director) on 6/12/18, at approximately 5:00 PM confirmed that the MDR had been intermittently closed due to food and nutrition staffing shortage within the past couple of months. E31 revealed a scheduled dietary aide, E38, had an unexpected event in which E38 was not able to work during the dinner meal on 6/9/18. E31 related that s/he instructed E37 not to close the MDR for the dinner but rather to secure the assistance from the nursing department. In addition, E37 related to the surveyor that E37 would have come into the facility to assist with the dinner meal on 6/10/18, if s/he was made aware. E37 related s/he was informed afterwards that the MDR was closed for the 6/9/18 dinner service.	F 802	3. The dining director will develop on or before July 31, 2018 a staffing plan to enable the operation for the dining room despite staffing to include effective communication to the director. The plan will be posted in the dietary department, and the dining room. The plan will be reviewed with department heads and weekend manager's on duty for implementation.  4. Dining observations will be performed daily for 4 weeks, then weekly for 4 weeks, then monthly for 2 months or until 100% compliance is observed. CED will monitor resident satisfaction through monthly resident council meetings as an ongoing process.		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)  §483.60(i) Food safety requirements. The facility must -	F 812		7/31/18	



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F 812	Continued From page 96  §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.  §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation it was determined that the facility failed to distribute meals under sanitary conditions on one (Homestead) out of 3 nursing units on several occasions. Findings include:  6/4/18 (11:30 AM - 12:30 PM) - Lunch observation on Homestead (memory support) unit: - Plates, bowls, cups and mugs previously stacked and /or arranged on the counter/table. - E10 (RN) touched drinking edge of R7's cup with contaminated gloves after E10 touched own face. - E39 (CNA) uncovered and passed a pre-plated puree meal to a server. E39 put a pre-made sandwich on the plate with his/her hands then cut it in half using hands to hold the sandwich in place Spooned beets onto the plate and passed to server. E39 removed tongs from service tray holding the pre-made sandwiches and placed the	F 812	1. The memory support unit is providing meals under sanitary conditions per regulations.  2. Current residents on the memory support unit could be affected. Staff were immediately educated on safe food handling and meal delivery.  3. The dining director will educate memory care staff and dementia director on safe food handling to include proper hand hygiene and proper glove use.  4. The dining director and the dementia director will perform daily dining observations for 4 weeks, then weekly for 4 weeks, then monthly for 2 months or until 1005 compliance is obtained. The dining director will report finding to the		

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F 812	Continued From page 97 tongs to the side. Two additional puree meals were uncovered and handed to the server. 21 sandwiches were plated and cut using the same gloved hands.  6/8/18 (11:45 AM - 12:50 PM) - Lunch observation on Homestead unit: - E12 (CNA) and E22 (CNA) removed the clean plates, bowls, cups from the cart and placed on kitchenette counter with bare hands. - E12 touched drinking edge of styrofoam cups with bare hands: 6 cups when counting and 5 cups when placing on the serving tray. - E10 touch sides of his/her shirt and pants with both hands, then touched the drinking edge of two glasses. Changed gloves without hand hygiene. - E12 began to dish out bowls of soup, then opened the cart door to remove serving utensils contaminating the gloves. While waiting for staff to obtain more bowls and forks from the kitchen, E10 began plating chicken and dumplings and vegetables. E12 touched the kitchen counter with the left hand then plated a pre-made grilled cheese using the same gloved hand.  Staff observed during lunch observations performing hand hygiene and drying hands with the contaminated paper towels used to turn off the faucet: 6/4/18: E10 (RN) 6/8/17: E10, E21 (LPN), E22 (CNA)  Findings were reviewed with E1 (NHA), E2 (DON) and E40 (CRN) on 6/15/18 at approximately 11:30 AM during the exit conference.	F 812	CED for further evaluation or recommendations.		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		7/31/18	

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F 880	Continued From page 98  §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; (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:	F 880			

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F 880	<p>Continued From page 99</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(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</p> <p>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§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 record review and interview it was determined that the facility failed to maintain an effective infection control program by not ensuring that one (R114) out of 5 sampled residents, newly admitted, received appropriate tuberculosis screening. Findings include:  Review of R114's clinical record revealed:  5/10/18 - Admission to facility.</p>	F 880	<ol style="list-style-type: none"> <li>1. R114 has received a 1st and 2nd step PPD</li> <li>2. New admissions or re-admissions could be affected to include current residents who potentially could be exposed.</li> <li>3. Root Cause: Resident was temporarily moved to a private room on a different nursing unit upon admission for treatment</li> </ol>	

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F 880	Continued From page 100 May, 2018 and June, 2018 - MAR documented R114 received the first tuberculosis skin test on 5/18/18, eight days after admission. There was no evidence that a second (step 2) skin test was performed.  During an interview on 6/14/18 at 8:30 AM E6 (RN) confirmed that no information could be found about a second tuberculosis skin test for R114.  Findings reviewed on 6/15/18, at approximately 11:30 AM with E1 (NHA), E2 (DON), and E40 (CRN) during the exit conference.	F 880	of head lice. The change is units interrupted the normal admission process for immunizations. New admission immunization audits will be performed daily at each morning clinical meeting.  4. CNE and nurse managers will perform new admission immunization audits daily for 4 weeks, then weekly for 2 weeks, then monthly for 2 months or until 100% compliance is obtained. The CNE will report findings to the QAPI committee monthly for further recommendations or evaluation until resolve.	
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; (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	F 883		7/31/18

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F 883	<p>Continued From page 101</p> <p>immunization; and</p> <p>(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.</p> <p>§483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-</p> <p>(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;</p> <p>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;</p> <p>(iii) The resident or the resident's representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:</p> <p>(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and</p> <p>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview it was determined that the facility failed to ensure that medical records included documentation of the influenza immunization for one (R6) out of 5 sampled residents for medication review.</p> <p>Findings include:</p>	F 883	<p>1. R6 no longer resides at the center, no opportunity to correct.</p> <p>2. New admissions or re-admissions could be affected.</p>		

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F 883	Continued From page 102  Review of R6's clinical record revealed:  10/24/17 - R6 was admitted to facility. There was no documentaion to show if R6 received or refused the influenza immunization.  During an interview on 6/14/18 at 8:30 AM, E6 (RN) confirmed that no information could be found.  Findings reviewed on 6/15/18, at approximately 11:30 AM with E1 (NHA), E2 (DON), and E40 (CRN) during the exit conference.	F 883	3. Root Cause: Center lacked a system to monitor immunizations on admission. New admission immunization audits will be performed daily at each morning clinical meeting.  4. CNE and nurse managers will perform new admission immunization audits daily for 4 weeks, then weekly for 2 weeks, then monthly for 2 months or until 100% compliance is obtained. The CNE will report findings to the QAPI committee monthly for further recommendations or evaluation until resolve.		
F 925 SS=F	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4)  §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation it was determined that the facility failed to have an effective pest control program. Findings include:  1. During lunch observation on 6/4/18 at 12:00 PM a fly was observed flying between two dining tables. Around the same time, R101 swatted twice at the fly, and R27 asked R101 if s/he was able to hit it.  2. On 6/5/18 at approximately 12:30 PM, a spider was observed hanging in the East South Hallway and E20 (CNA) was present during this observation and confirmed its presence.  3. On 6/5/18 at 2:00 PM, a fly was observed in	F 925	1. Center is working with pest management vendor for the effective treatment and interventions.  2. All current residents could be effected.  3. Root Cause: Change in weather conditions created an increase in fly observations within the center. The center performed aggressive measures to include fly treatment, traps, and lights to diminish fly concerns. Staff have been informed to assist with pest management by not leaving food or food trays out, and timely trash removal. Entrance and exit doors, and water drains have been treated	7/31/18	

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F 925	<p>Continued From page 103 the living room.</p> <p>4. On 6/5/18 at 2:36 PM, a fly was at Nurse's Station 2, and E62 (LPN) at the desk said "This fly is playing with me!" while swatting at it.</p> <p>5. On 6/9/18 at approximately 5:10 PM, a fly was observed circulating in the East Nursing Station.</p> <p>6. On 6/9/18 from approximately 5:45 PM to 6:12 PM, two flies were observed on the coffee cart in the East South Hallway while two CNAs, E24 and E25, were distributing the dinner meals.</p> <p>7. On 6/12/18 at approximately 12:15 PM, when this surveyor was carrying a test plate out of the dining room an unknown employee said s/he'd get a cover, and R70 said this was important, otherwise "you could be eating fly eggs. They are terrible. I have a fly swatter."</p> <p>8. On 6/13/18 at 12:00 PM, a fly was observed at Nurse's Station 1.</p> <p>Although the facility had an active pest control contract, and the Summaries of Service showed that the pest control company had treated for house flies on two recent visits, the pest control had not been effective.</p> <p>An interview, on 6/13/18 at approximately 9:20 AM, with E23 (Maintenance Supervisor) revealed that s/he was made aware of problems with flies last week (week ending 6/10/18), contacted the pest control company and interventions were implemented. E23 confirmed that s/he was not made aware of the spider observed on 6/5/18.</p> <p>Findings reviewed on 6/15/18, at approximately</p>	F 925	<p>and continue to be reviewed weekly.</p> <p>4. The Maintenance director will perform daily rounds to observe the effectiveness of treatment and interventions for pest control. The pest management vendor will perform weekly visits for further treatment and interventions. This will be an going process until resolved. The maintenance director will report findings to the QAPI monthly for further recommendation and evaluations until resolved.</p>	
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F 925	Continued From page 104 11:30 AM with E1 (NHA), E2 (DON), and E40 (CRN) during the exit conference.	F 925			



**NAME OF FACILITY:** Milford Center

**DATE SURVEY COMPLETED:** June 15, 2018

STATEMENT OF DEFICIENCIES SECTION Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
<p><b>The State Report incorporates by reference and also cites the findings specified in the Federal Report.</b></p> <p>An unannounced annual and complaint survey was conducted at this facility from May 31, 2018 through June 15, 2018. The facility census the first day of the survey was 125 (one hundred twenty five). An emergency preparedness survey was also conducted during the same time period. There were no emergency preparedness deficiencies based on observation and interviews.</p> <p><b>3201 Regulations for Skilled and Intermediate Care Facilities</b></p> <p><b>3201.1.0 Scope</b></p> <p><b>3201.1.2</b></p> <p><b>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.</b></p>	<p>Cross Refer to the CMS 2567-L survey completed June 6, 2018: F550, F565, F575, F580, F584, F609, F637, F641, F644, F655, F656, F657, F676, F679, F684, F686, F689, F690, F710, F725, F732, F745, F756, F758, F802, F812, F880, F883 and F925.</p>	<p>July 31, 2018</p>

Provider's Signature *Kathleen H. Quinn*

Title *CEO*

Date *7/15/18*



**DELAWARE HEALTH AND SOCIAL SERVICES**

Division of Long Term Care  
Residents Protection

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

**STATE SURVEY REPORT**

**NAME OF FACILITY:** Milford Center

**DATE SURVEY COMPLETED:** June 15, 2018

STATEMENT OF DEFICIENCIES SECTION Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE												
<p><b>This requirement is not met as evidenced by:</b></p> <p>Cross Refer to the CMS 2567-L survey completed June 6, 2018: F550, F565, F575, F580, F584, F609, F637, F641, F644, F655, F656, F657, F676, F679, F684, F686, F689, F690, F710, F725, F732, F745, F756, F758, F802, F812, F880, F883 and F925.</p> <p><b>16 Del. C., 1162</b></p> <p><b>Nursing Staffing:</b></p> <p><b>(c) By January 1, 2002, the minimum staffing level for nursing services direct caregivers shall not be less than the staffing level required to provide 3.28 hours of direct care per resident per day, subject to Commission recommendation and provided that funds have been appropriated for 3.28 hours of direct care per resident for Medicaid eligible reimbursement.</b></p> <p><b>Nursing staff must be distributed in order to meet the following minimum weekly shift ratios:</b></p> <table border="0" data-bbox="282 1451 735 1625"> <thead> <tr> <th></th> <th><b>RN/LPN</b></th> <th><b>CNA*</b></th> </tr> </thead> <tbody> <tr> <td><b>Day</b></td> <td><b>1 nurse per 15 res.</b></td> <td><b>1 aide per 8 res.</b></td> </tr> <tr> <td><b>Evening</b></td> <td><b>1:23</b></td> <td><b>1:10</b></td> </tr> <tr> <td><b>Night</b></td> <td><b>1:40</b></td> <td><b>1:20</b></td> </tr> </tbody> </table> <p><b>* or RN, LPN, or NAIT serving as a CNA.</b></p> <p><b>(g) The time period for review and determining compliance with the staffing ratios under this chapter shall be one (1) week.</b></p> <p>The law was not met as evidenced by:</p>		<b>RN/LPN</b>	<b>CNA*</b>	<b>Day</b>	<b>1 nurse per 15 res.</b>	<b>1 aide per 8 res.</b>	<b>Evening</b>	<b>1:23</b>	<b>1:10</b>	<b>Night</b>	<b>1:40</b>	<b>1:20</b>	<p>1. Center has maintained 3.28 staffing hours of direct care per resident per day.</p> <p>2. Any resident could be affected. Center has hired a new labor manager.</p> <p>3. The new labor manager performs daily and weekly forecasts of staffing to monitor compliance.</p> <p>4. The labor manager reports daily to the administrator to confirm staffing is maintained according to census.</p>	<p>7/31/2018</p>
	<b>RN/LPN</b>	<b>CNA*</b>												
<b>Day</b>	<b>1 nurse per 15 res.</b>	<b>1 aide per 8 res.</b>												
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**DELAWARE HEALTH  
AND SOCIAL SERVICES**

Division of Long Term Care  
Residents Protection

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

**STATE SURVEY REPORT**

**NAME OF FACILITY:** Milford Center

**DATE SURVEY COMPLETED:** June 15, 2018

STATEMENT OF DEFICIENCIES SECTION Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
<p>Milford Center failed to meet the daily 3.28 Care Hours per Resident minimum on ONE (1) date, that being Saturday, 9 June 2018. The care hours per resident attained by the provider on that date was 3.09</p>		