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

DHSS - DHCQ
263 Chapman Road, Ste 200, Cambridge Bldg.
Newark, Delaware 19702
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: WillowBrooke Court at Cokesbury Village DATE: SURVEY COMPLETED: September 3, 2024

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	An unannounced Annual, Complaint and Emergency Preparedness survey was conducted at this facility from August 30, 2024, through September 3, 2024. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census on the first day was thirty-two. The sample totaled fourteen residents.		
3201	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.0	**Scope**		
3201.1.1	**A Nursing facility (NF) is a residential institution, as defined in 16 Delaware Code §1102(4), which provides services to residents which include resident beds, continuous nursing services, and treatment services for individuals who do not currently require continuous hospital care. Care is given in accordance with a physician's orders and requires the competence of a registered nurse (RN).**		
	Based on record review and interview, it was determined that for one (R107) out of twelve residents reviewed for assessments, the facility failed to meet the professional standards of the State of Delaware by having a licensed practical nurse (LPN) complete several of R107's admission assessments. Findings include: "Delaware State Board of Nursing – RN, LPN and NA/UAP Duties 2024...Admission Assessments * - RN (registered nurse) ...* = Once a care plan is established, the LPN may do assessments...".	1) It was outside the timeline parameter to correct R107's admission assessments to be completed by an RN but all assessments completed by the LPN were reviewed for accuracy by DON on 8/29/24. 2) Review of current residents performed by DON. No other residents had initial assessments performed by LPN. 3) DON or designee will provide education to nursing staff on Scope of Practice to ensure all admission/initial assessments are completed by an R.N. 4) A root cause analysis determined that there was a knowledge deficit	11/15/24

Provider's Signature K Perrone Title NHA Date 9-24-24

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	8/13/24 – R107 was admitted to the facility with diagnoses including, but not limited to Alzheimer's dementia. 8/13/24 – R107's admission forms labeled falls risk evaluation, pain status report, Braden scale for predicting pressure ulcer risk evaluation and assessment for bowel and bladder rehabilitation/retraining/restorative program were documented as completed by "65180" in the facility's electronic medical record (EMR). 8/30/24 8:55 AM – During an interview, E3 (DON) confirmed that there were approximately fifteen forms involved in the facility's admission process that were filled out by various staff including nurses, aides, social workers, activities personnel and dietician. E3 stated that the admission forms that were under the purview of the nurse included: nursing skilled evaluation, fall risk evaluation, Braden scale for predicting pressure ulcer risk evaluation, wandering risk evaluation, pain status report, assessment for bowel and bladder rehabilitation/retraining/restorative program and the baseline care plan. 8/30/24 12:10 PM – During an interview, E3 (DON) confirmed that "65180" employee number in the EMR was assigned to E11 (LPN), who was a licensed practical nurse. The facility failed to meet the professional standard as required by the State of Delaware that requires a RN to perform a resident's admission assessments upon admission to a facility.	about the scope of practice for licensed nurses. New admission assessments will be audited by DON or designee once weekly x 2 weeks. If 100% compliant, then biweekly x 4 weeks, If 100% compliant, then monthly x 1 month. If 100% compliant, request to discontinue audits will be submitted to QAPI committee by DON. All audits will be submitted to and reviewed by the facility QAPI committee.	

Provider's Signature K Perrone Title NHA Date 9/24/24

NAME OF FACILITY: WillowBrooke Court at Cokesbury Village DATE: SURVEY COMPLETED: September 3, 2024

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	9/3/24 2:00 PM – Findings were reviewed with E1 (ED), E2 (NHA), E3 (DON) and E4 (ADON) at the exit conference.		
3201.1.2	**Nursing facilities shall be subject to all applicable local, state, and federal code requirements. The provisions of 42CFR Ch. IV Part 483, Subpart B, requirements for Long Term Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** This requirement is not met as evidenced by: Cross Refer to the CMS 2567-L survey completed September 3, 2024: cross refer: F756, F812 and F880 **F880** **§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 §483.71 and following accepted national standards;**	1)Order obtained for EBP for R1 and R109 on 8/29/24 2)Review of current residents performed by DON. No other residents require EBP. 3) DON or designee will provide education to nursing staff on Enhanced Barrier Precautions. 4) A root cause analysis determined that there was a knowledge deficit of the nursing staff of residents requiring EBP, and the need to list organism name on infection log. Active residents will be audited by DON or designee for presence of condition requiring EBP once weekly x 2 weeks. If 100% compliant, then bi-weekly x 4 weeks, If 100% compliant, then monthly x 1 month. If 100% compliance, request to discontinue audits will be submitted to QAPI committee by DON. All audits will be submitted to and reviewed by the facility QAPI committee.	11/15/24

Provider's Signature K Perrone Title NHA Date 9-24-24

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	§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.		

Provider's Signature K Perrone Title NHA Date 9-24-24

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	§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. **§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.** This requirement was not met as evidenced by: Based on observation, interview, and record review, it was determined that for one (R104) out of one resident review for infection control, the failed to implement enhanced barrier protections (EBP) for R104's use of an indwelling urinary catheter. Findings include: As per CDC (Centers for Disease Control and Prevention) definition (6/28/24), Enhanced Barrier Precautions are an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes. Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices). Review of R104's clinical records revealed: 3/10/24 – R104 was admitted to the facility with diagnoses including kidney cancer and bladder obstruction. 6/21/24 – R104's physician's orders documented, "Foley catheter 18 French (a type of urinary catheter that drains urine from the bladder into a collection bag.)"		

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	8/28/24 12:00 PM – R104 was observed sitting in his room. A covered urinary collection bag was hanging on the back of the wheelchair. 8/28/24 1:00 PM – R104 was observed sitting on the toilet in his room. E10 (CNA) entered the bathroom and exited with R104 approximately ten minutes later. The surveyor asked E10 what service she provided for R104. E10 stated, "I cleaned him up and helped him get off the toilet." The surveyor asked E10 what kind of protective equipment was used when the care was provided, E10 stated, "I wore gloves." 8/29/24 2:30 PM – The surveyor observed R104's bathroom call bell ringing. E9 (CNA) entered the bathroom and exited with R104 approximately 10 minutes later. The surveyor asked E9 what type of care was provided. E9 stated, "I emptied the foley bag and cleaned him up because my shift will end soon." The surveyor asked E9 what type of protective equipment was worn when the urinary collection bag was emptied. E9 stated, "I wore gloves when I emptied the foley." E9 was asked if any other type of protective equipment was worn, E9 stated, "No." The surveyor asked E9 if she knew what it meant to use "Enhanced barrier protection." E9 stated, "It means I must wear gloves when I help the residents to clean up." 8/29/24 3:00 PM – A review of R104's care plans, physician's orders, and activities of daily living records (ADLs) lacked evidence of documentation for enhanced barrier protection.		

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	The facility failed to implement enhanced barrier protection for a resident with an indwelling urinary catheter. 9/3/24 2:00 PM – Findings were reviewed with E1 (ED), E2 (NHA), E3 (DON) and E4 (ADON) at the exit conference.		
3201.6.0	**Services to Residents**		
3210.6.9.2	**Specific Requirements for Tuberculosis**		
3201.69.2.3	**The facility shall have on file the results of tuberculin testing performed on all newly placed residents.** This requirement was not met as evidenced by: Based on record review and interview, it was determined that for one (R107) out of nine residents reviewed for infection control, the facility failed to test and document the results of R107's tuberculosis (TB) testing on admission. Findings include: 8/13/24 – R107 was admitted to the facility with diagnoses including, but not limited to Alzheimer's dementia. 8/28/24 – Review of R107's immunization records revealed a lack of documentation of TB testing, now fifteen days after R107's admission to the facility. 8/29/24 4:10 PM – During an interview, E3 (DON) stated, "We missed testing [R107] for TB. We are placing it today.	1)Order obtained for tuberculin test for R107 on 8/29/24. Test administered on 8/29/24. (read 8/31/24) and 9/7/24 (read 9/10/24), both with negative results. 2)Review of current residents reviewed by DON. All residents up to date with 2-step TB testing and recorded results. 3) DON or designee will provide education to nursing staff on 2-step TB requirements when a resident is admitted. 4) A root cause analysis determined that there was a knowledge deficit of the nursing staff of 2-step TB requirements for new residents. All new admissions will be audited by DON or designee for tuberculosis testing and recording of results once weekly x 2 weeks. If 100% compliant, then biweekly x 4 weeks, If 100% compliant, then monthly x 1 month. If 100% compliance, request to discontinue audits will be submitted to QAPI committee by DON. All audits will be submitted to and reviewed by the facility QAPI committee.	11/15/24
Title 16 Health and Safety Chapter 11 Long-Term Care	**1123. Notice to resident.** **(a) The Department must prepare a notice that includes § 1121 of this title in its entirety. This notice must be available in a**		

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facilities and Services Subchapter II Rights of Residents	**language and format that is accessible to each resident or their authorized representative under § 1122 of this title.** **(b) Each long-term care facility must post the notice described in subsection (a) of this section conspicuously in a public area of the facility.** **(c) Each long-term care facility must furnish copies of the notice required under subsection (a) of this section to all of the following:** **(1) Each resident upon admittance to the facility.** **(2) All residents currently residing in the facility.** **(3) Each authorized representative under § 1122 of this title.** **(d) The long-term care facility must retain in its files a statement signed by each individual listed in subsection (c) of this section that the individual has received a copy of § 1121 of this title.** This requirement was not met as evidenced by: Based on record review and interview, it was determined that for two (R101 and R106) out of twelve residents reviewed for resident rights, the facility failed to furnish copies of the residents' rights to R101 and R106's authorized representative. Findings include: 1. Review of R101's clinical record revealed: 10/1/99 – R101's Power of Attorney (POA) documented FM1 (R101's son/DPOA) as	1. R101 and R106 resident rights forms were submitted to and signed by their respective Responsible Parties. 2. Social Services Coordinator educated on only allowing residents without cognitive deficits to sign their own resident right notices. Responsible Parties are to sign for residents with a BIMS score showing cognitive deficits. 3. Social Services Coordinator will audit all current residents' BIMs score at the time the Resident Rights forms were signed. New forms will be submitted to and signed by respective Responsible	11/15/24

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	R101's durable power of attorney in the event of cognitive impairment. 7/4/23 – R101 was admitted to the facility with diagnoses including but not limited to dementia. 5/24/24 – R101's quarterly Minimum Data Set (MDS) documented a Basic Inventory of Mental Status (BIMS) score of 6, which was reflective of a severe cognitive impairment. 6/5/24 – R101 signed the updated Delaware Resident Rights form. 8/28/24 – A review of R101's clinical record confirmed that R101, who at the time had a BIMS score of 6 which is reflective of severe cognitive impairment, signed the notice stating that she was made aware of her resident rights. At the time that R101 signed the Resident Rights document, the facility was in possession of R101's DPOA paperwork and had assessed R101 as having a severe cognitive impairment. 2. Review of R106's clinical record revealed: 8/14/15 – R106's General Power of Attorney (POA) documented FM2 (R106's daughter/POA) as R106's power of attorney in the event of cognitive impairment. 11/7/22 - R106 was admitted to the facility with diagnoses including but not limited to dementia. 4/25/24 - R106's quarterly MDS documented a BIMS score of 7, which was reflective of severe cognitive impairment.	Parties if the resident BIMs score reveals any cognitive deficit. 4. A root cause analysis determined that there was a knowledge deficit of the Social Services Coordinator relating to cognitive deficits and ability to sign resident right notices. All new admissions will be audited by Social Services Coordinator or designee for BIMS score and signing of resident rights notice once weekly x 2 weeks. If 100% compliant, then biweekly x 4 weeks, If 100% compliant, then monthly x 1 month. If 100% compliance, request to discontinue audits will be submitted to QAPI committee by Social Services Coordinator. All audits will be submitted to and reviewed by the facility QAPI committee.	

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	6/17/24 – R106 signed the updated Delaware Resident Rights form. 8/28/24 – A review of R106's clinical record confirmed that R106, who at the time had a BIMS score of 7 which is reflective of severe cognitive impairment, signed the notice stating that she was made aware of her resident rights. At the time that R106 signed the Resident Rights document, the facility was in possession of R106's DPOA paperwork and had assessed R106 as having a severe cognitive impairment. 8/29/24 4:15 PM – During an interview, E3 stated that the facility utilized the BIMS score to determine if a resident was capable of making their own decisions or if the POA needed to be involved. 9/3/24 2:00 PM – Findings were reviewed with E1 (ED), E2 (NHA), E3 (DON) and E4 (ADON) at the exit conference.		

Provider's Signature K Reeves Title NHA Date 9-24-24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085017	A. BUILDING _____ B. WING _____	C 09/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOKE COURT AT COKESBURY VILLAGE	726 LOVEVILLE ROAD HOCKESSIN, DE 19707

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Annual and Complaint survey was conducted at this facility from August 28, 2024 through September 3, 2024. The facility census was two on the first day of the survey. In accordance with 42 CFR 483.73, an Emergency Preparedness survey was also conducted by The Division of Health Care Quality, the Office of Long-Term Care Residents Protection at this facility during the same time period. Based on observations, interviews, and document review, no Emergency Preparedness deficiencies were identified.	E 000		
F 000	INITIAL COMMENTS An unannounced Annual, Complaint and Emergency Preparedness Survey was conducted at this facility from August 28, 2024 through September 3, 2024. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census on the first day was two residents. The sample totaled two residents. Abbreviations/definitions used in this report are as follows: CNA- Certified Nurse's Aide; DON- Director of Nursing; ED- Executive Director; LPN- Licensed Practical Nurse; NA - nurse's aide; NHA- Nursing Home Administrator; NP- Nurse Practitioner; RN- Registered Nurse; UAP - unlicensed assistive personnel;	F 000		

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

Electronically Signed | 09/24/2024

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

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F 000	Continued From page 1 BIMS- Basic Inventory of Mental Status; a medical tool that is utilized to determine cognitive function. The score ranges from 0 to 15. 13 to 15 points suggests cognition is intact, 8 to 12 points suggests moderate cognitive impairment, 0 to 7 points suggests severe cognitive impairment; Cerebral Vascular Accident (CVA) - stroke; EMR - electronic medical record; Gastrostomy tube (an indwelling medical device for liquid nutrition, fluids and medications) into the stomach; MDRO - multi-drug resistant organism, a pathogen that causes an infection that does not respond to multiple antibiotics; Milligram (mg) - metric unit of weight, 1 mg equals 0.0035 ounce; PICC- percutaneous inserted central catheter, an indwelling medical device that provides acccess to the patient's venous system for medications; TB - tuberculosis;	F 000		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph	F 756		11/15/24

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F 756	Continued From page 2 (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R1) out of two residents reviewed for medications, the facility failed to ensure that the admission pharmacy review of medications identified the correct route of medication administration. Findings include: Review of R1's clinical record revealed: A review of a facility policy titled "Resident Health Services Manual, Policies and Procedures, Subject: Drug Regimen Review, revised 2/19"	F 756	1) Order changed for R1 to correct route of administration on 8/29/24. 2) Review of current residents performed by DON. No other residents requiring enteral medication administration. 3) DON or designee will confirm education is provided to Pharmacy Consultant to review F756 and to ensure route of administration is checked for all medication recommendations (see attached education). 4) A root cause analysis determined that the pharmacy consultant failed to identify the correct route of medication for a	

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F 756	Continued From page 3 revealed: "Policy: ... Drug Regimen Review Includes: ...A review of the drug regimen to identify, and if possible, to prevent potentially clinically significant medication adverse consequences. Clinically significant medication issues may include, but are not limited to: ... Medication dose, frequency, route, or duration not consistent with resident's condition ... ." 8/16/24 - R1 was admitted to the facility directly from a hospitalization after an acute stroke. R1's hospital discharge records revealed that R1 now had swallowing difficulties resulting from the stroke and that R1 was not to have anything by mouth because R1 could not swallow safely. R1 had a gastrostomy tube (tube for liquid nutrition, fluids and medications) inserted into her stomach during her hospitalization and the tube was in place at R1's facility admission. R1's facility admission diet was ordered as nothing by mouth diet and with an Enteral (stomach) Feed Order for nutrition. R1's admission medications were ordered to be administered via her feeding tube. The following medication was ordered on 8/16/24: Aspirin Tablet Chewable 81 mg, Give 1 tablet by mouth once a day for CVA. 8/19/24 - A pharmacy medication review was completed by P1 (Consulting Pharmacist). The report revealed "Based upon the information ...the resident's medication regimen contained no new irregularities ... ." 8/29/24 3:15 PM - During an interview, E6 (RN) confirmed the aspirin 81mg was ordered to be given to R1 by mouth. 9/3/24 12:15 PM - During an interview, P2 (Consulting Pharmacy Clinical Manager)	F 756	resident requiring enteral medication administration. All Medication Regimen Reviews for our facility will be copied to clinical pharmacy manager and audited by second consultant pharmacist daily x 1 week, and if 100% compliant, 3 times weekly x 1 week, and if 100% compliant, twice weekly x 1 week, and if 100% compliant, every two weeks x 2 weeks. If 100% compliant, request to discontinue audits will be submitted to QAPI committee by pharmacy consultant. All audits will be submitted to and reviewed by the facility QAPI committee.	

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F 756	Continued From page 4 confirmed that the route of medication administration is a component of a pharmacy medication regimen review and that R1's 8/19/24 review of medications did not identify the incorrect oral route for the aspirin order. The pharmacy review did not identify the incorrect medication route of admistration for the aspirin. 9/3/24 2:00 PM - Findings were reviewed with E1 (ED), E2 (NHA), E3 (DON) and E4 (ADON) at the exit conference.	F 756		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of other facility documentation it was determined	F 812	1.Graham Crackers were rewrapped immediately. Carrots and Potatoes were	10/23/24

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F 812	Continued From page 5 that the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety. Findings include: 8/28/24 9:30 AM thru 9:45 AM - An initial observation of the facility kitchen revealed the following: -Dry food storage area: uncovered graham cracker crumbs. -Walk in refrigerator: unlabeled pies, a large unlabeled casserole, uncovered potatoes and carrots. -Walk in freezer: an unidentified frozen portion of meat was stored in the freezer. Additionally, the gasket to the freezer was not completely sealed, which allowed outside air to flow into the freezer and caused ice to buildup on the floor and shelving at the entrance to the freezer. -Environment: the paint was peeling from the wall in the chemical storage area. 8/28/24 12:30 PM - A cooling fan in use in the dish washing area was noted to have dust and debris. The wall positioned to the right side of the fan also contained dust and debris. 9/3/24 2:00 PM - Findings were reviewed with E1 (ED), E2 (NHA), E3 (DON) and E4 (ADON) at the exit conference.	F 812	covered with a lid. Pies were labeled Discussed with staff the importance of items being covered and labeled. 2. Sous Chefs to have an in-service daily on covering, labeling and dating x 2 weeks for all culinary team members. 3. Sous Chefs will audit all storage areas and walkins and document on opening checklist. 4. A root cause analysis revealed that a routine auditing system was not in place. Checklists will be reviewed by the Culinary Director or designee for compliance once weekly x 2 weeks. If 100% compliant, then biweekly x 4 weeks, If 100% compliant, then monthly x 1 month. If 100% compliant, request to discontinue audits will be submitted to QAPI committee by Culinary Director. All audits will be submitted to and reviewed by the facility QAPI committee. 1.The unidentified meat was thrown out immediately. Walk in freezer was immediately audited to ensure that all items were labeled. There were no other unlabeled items present. 2. Sous Chefs to have in service daily x 2 weeks with the culinary team on importance of labeling and dating items. 3. Sous Chefs will check all storage areas and walkins daily and document results on opening checklist.	

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F 812	Continued From page 6	F 812	4. A root cause analysis revealed that a routine auditing process was not in place. Checklists will be reviewed by the Culinary Director or designee for compliance once weekly x 2 weeks. If 100% compliant, then biweekly x 4 weeks, If 100% compliant, then monthly x 1 month. If 100% compliant, request to discontinue audits will be submitted to QAPI committee by the Culinary Director. All audits will be submitted to and reviewed by the facility QAPI committee. 1.The Gasket was replaced. Peeling paint was addressed and walls were re-painted. 2. Culinary team was educated by the culinary supervisors to immediately report to the supervisors any presence if peeling paint in their work area. They were also educated to report to their supervisor any ice crystal formation at the freezer gasket seal, that would indicate a compromised seal. 3.Gasket seal will be audited by the Sous Chef daily and document results on the opening checklist. 4. A root cause analysis revealed that there was not an established process for the culinary team to report repairs. Checklists will be reviewed by the Culinary Director or designee for compliance once weekly x 2 weeks. If 100% compliant, then biweekly x 4 weeks, If 100% compliant, then monthly x 1 month. If 100% compliant, request to discontinue audits will be submitted to QAPI	

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F 812	Continued From page 7	F 812	committee by the Culinary Director. All audits will be submitted to and reviewed by the facility QAPI committee. 1.The fan was immediately cleaned, along with adjacent walls. 2. Upon inspection of entire kitchen area, no other standing fans were present. 3. Sous Chefs will check all walls and fan for cleanliness daily and document results on opening checklist. The fans and neighboring walls were placed on a weekly cleaning schedule. The fan and walls were added to the utility cleaning checklist. Culinary team was educated by the culinary supervisors to clean fans and walls weekly. 4. A root cause analysis revealed that a routine auditing process was not in place and a fan cleaning schedule was not in place. Updated utility cleaning checklists and opening checklists will be reviewed by the Culinary Director or designee for compliance once weekly x 2 weeks. If 100% compliant, then biweekly x 4 weeks, If 100% compliant, then monthly x 1 month. If 100% compliant, request to discontinue audits will be submitted to QAPI committee by the Culinary Director. All audits will be submitted to and reviewed by the facility QAPI committee.	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control	F 880		11/15/24

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F 880	Continued From page 8 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 §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism	F 880		

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F 880	Continued From page 9 involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for two (R1and R109) out of three residents reviewed for infection control, the facility failed to establish and maintain an infection control program using enhanced barrier precautions. For R1, the presence of an indwelling feeding tube was criteria for Enhanced Barrier Precautions (EBP). R109 was admitted with PICC (percutaneously inserted central catheter) line and was diagnosed as colonized with enterococcus faecium VRE; both of which are criteria for EBP. Also the facility line listing did not specify the name of the pathogen. Findings	F 880	1) Order obtained for EBP for R1 and R109 on 8/29/24. 2) Review of current residents performed by DON. No other residents require EBP. Infection log up to date with organism names for all active infections. The organism was reported timely to DHSS on 6/5/24 in compliance with mandated reporting of MDROs (see attached Epidemiology Report). 3) Infection Preventionist or designee will provide education to nursing staff on Enhanced Barrier Precautions. DON will	

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F 880	Continued From page 10 include: As per CDC (Centers for Disease Control and Prevention) definition (6/28/24), Enhanced Barrier Precautions are an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes. Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices). 1. Review of R1's clinical record revealed: 8/16/24 - R1 was admitted to the facility after being hospitalized for a stroke, which included the insertion of a gastrostomy tube. 8/28/24 12:15 PM and 8/29/24 12:20 PM - During observations, E6 (RN) administered medications to R1 by way of her gastrostomy tube, and E6 did not wear a gown to adhere to Enhanced Barrier Precautions. 8/29/24 12:30 PM - During an interview E6 confirmed that she did not wear a gown for Enhanced Barrier Precautions while administering medications to R1 by way of her gastrostomy tube. 2. Review of R109's clinical record revealed: 5/23/24 - E12 (MD) completed R109's admission history and physical (H&P). 6/5/24 - R109's urine culture was reported to the	F 880	provide education to ADON/Infection Preventionist and RN Supervisor to include organism name in surveillance log. 4) A root cause analysis determined that there was a knowledge deficit of the nursing staff of residents requiring EBP, and the need to list organism name on infection log. Active residents will be audited by Infection Preventionist or designee for presence of condition requiring EBP once weekly x 2 weeks. If 100% compliant, then biweekly x 4 weeks, If 100% compliant, then monthly x 1 month. If 100% compliant, request to discontinue audits will be submitted to QAPI committee by Infection Preventionist or designee. All audits will be submitted to and reviewed by the facility QAPI committee.	

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F 880	Continued From page 11 facility as colonized (75,000 organism count) with enterococcus faecium VRE (vancomycin resistant enterococcus), which was a CDC-targeted MDRO. 6/5/24 - E13 (NP) ordered in R109's EMR, " ...Enhanced Barrier precautions (EBP) every shift for prevention of transmission of MDRO infections. Use for when infected or colonized with an MDRO or for wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with MDRO ...". 6/6/24 - E5 (NP) documented her initials on the lab report to acknowledge her awareness of the lab results. 6/20/24 - R109's Enhanced Barrier Precautions were discontinued. 6/27/24 - R109 was re-admitted to the facility from the hospital. 6/27/24 - E5 (NP) ordered in R109's EMR, " ...PICC dressing change weekly ...every Tuesday ...". 6/27/24 - E5 (NP) ordered in R109's EMR, " ...Enhanced Barrier Precautions every shift for prevention of transmission of MDRO infections. Use for when infected or colonized with an MDRO or for wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with MDRO ...". 7/1/24 - R109's Enhanced Barrier Precautions were discontinued. Enhanced Barrier Precautions were still	F 880		

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F 880	Continued From page 12 necessary for R109 due to his known history of urine colonization with enterococcus faecium VRE, a CDC-targeted MDRO. 7/3/24 - E5 (NP) ordered in R109's EMR, " ... Foley catheter ...Reason/DX (diagnosis): neurogenic bladder". Placement of a indwelling foley catheter was a second indication that R109 required enhanced barrier precautions. 8/9/24 - R109 was transferred to the hospital. At the time of R109's transfer back to the hospital, R109 spent 39 days (from 7/2/24 to 8/9/24) in the facility without the required Enhanced Barrier Precautions. 8/28/24 - A review of the facility Infection Surveillance Monthly report revealed that the facility failed to provide the name of the specific pathogen that the resident was infected or colonized with. 9/3/24 2:00 PM - The findings were reviewed with E1 (ED), E2 (NHA), E3 (DON) and E4 (ADON) at the exit conference.	F 880		