DELAWARE HEALTH AND SOCIAL SERVICES

Division of Health Care Quality
Office of Long Term Care Residents Protection

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

STATE SURVEY REPORT

NAME OF FACILITY: Shipley Living Health Care

DATE SURVEY COMPLETED: July 2, 2024

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	An unannounced Annual and Complaint Survey was conducted at this facility from June 24, 2024, through July 2, 2024. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documents as indicated. The facility census on the first day of the survey was sixty-eight (68). The survey sample totaled seventeen (17) residents.	
3201	**Regulations for Skilled and Intermediate Care Nursing Facilities**	
3201.1.0	**Scope**	
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** This requirement is not met as evidenced by: Cross Refer to the CMS 2567-L survey completed July 2, 2024: E0037, F550, F553, F558, F584, F609, F623, F638, F641, F645, F656, F657, F658, F677, F685, F689, F728, F730, F755, F838, F842, F880, F882, F883 and F947.	

Provider's Signature Eric Bond Title Executive Director Date 7-18-2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085031	A. BUILDING _____ B. WING _____	C 07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHIPLEY LIVING	2723 SHIPLEY ROAD WILMINGTON, DE 19810

(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 June 24, 2024 through July 2, 2024. The facility census was 68 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, Emergency Preparedness deficiencies were identified.	E 000		
E 037 SS=D	EP Training Program CFR(s): 483.73(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.542(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, REHs at §485.542, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years.	E 037		8/9/24

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

Electronically Signed | 07/26/2024

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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E 037	Continued From page 1 (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under	E 037		

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E 037	Continued From page 2 arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under	E 037		

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E 037	Continued From page 3 arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients,	E 037		

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E 037	Continued From page 4 personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This REQUIREMENT is not met as evidenced by: Based on document review and interview it was determined that for two (E27 and E28)) out of fifteen (15) sampled employees the facility failed to ensure that staff received Emergency Preparedness training upon hire and at least annually after that. Findings include: 7/2/24 11:34 AM - Review of facility provided documents revealed two (2) staff members were missing documented evidence of Emergency	E 037	Corrective Action: Corrective actions have been ensured by the Administrator and the Director of Nursing. The required Emergency Preparedness training will be completed by all staff, including therapy and activities departments. Identification of Other Residents: Current associates and residents have the	

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E 037	Continued From page 5 Preparedness training: - E27 (PT) - no documented Emergency Preparedness training provided. - E28 (Activites) - no documented Emergency Preparedness training provided. 7/6/24 9:27 AM - During interview, E21 (HR) acknowledged that the facility was unable to provide verification of emergency preparedness traing for E27 and E28. Findings were reviewed during the exit conference on 7/2/24 at 2:15 PM with E1 (NHA), E2 (DON) E3 (ADON), E4 (Clinical Specialist), E32 (Corporate PT) and State of DE Ombudsman (via telephone).	E 037	potential to be affected. To prevent others from being affected, the facility will complete an audit of current employees to monitor compliance with Emergency Preparedness training. System Changes: The Root Cause of the concern was a failure to adhere to the facility policy for Staff Development Program (rev. 5.2019). "The facility policy for Staff Development Program (rev. 5.2019) was reviewed and found to meet professional standards. "The facility system for managing the Staff Development Program has been updated to include a monthly review of compliance in the monthly Quality Assurance and Performance Improvement (QAPI) committee meeting. "The administrator or designee will provide outcomes of the monthly compliance monitoring to the QAPI Committee. Success Evaluation: "A weekly audit of new associate completion of Emergency Preparedness Training will be completed by the Human Resource Director or designee. "Audits will be completed weekly until 100% compliance is achieved for 3 consecutive evaluations, then every other week until 100% compliance is achieved for 3 consecutive evaluations, and then monthly until 100% compliance is achieved for 3 consecutive evaluations. "The results of the audits will be provided to the QAPI Committee monthly for the next 3 months to determine if any	

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E 037	Continued From page 6	E 037	continued monitoring is indicated to maintain compliance.	
F 000	INITIAL COMMENTS An unannounced Annual and Complaint Survey was conducted at this facility from June 24, 2024, through July 2, 2024. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documents as indicated. The facility census on the first day of the survey was sixty-eight (68). The survey sample totaled seventeen (17) residents. This requirement is not met as evidenced by: Abbreviations/definitions used in this report are as follows: ADON - Assistant Director of Nursing; Alzheimer's Disease - brain disorder causing loss of memory, thinking and language; BIMS (Brief Interview for Mental Status) - test to measure thinking ability with score ranges from 00 to 15: 13-15: Cognitively intact 08-12: Moderately impaired 00-07: Severe impairment; Braden Scale - tool to assess the risk of developing a pressure ulcer; carve out - services that a resident cannot receive when utilizing the part B of Medicare/ Medicaid insurance (when receiving rehab services) but these services are available once the resident converts back to their long-term care insurance of Medicare/Medicaid; CNA - Certified Nursing Assistant; CNS - Clinical nurse specialist;	F 000		

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F 000	Continued From page 7 DELVAX- a confidential online computer system used in Delaware by doctors, nurses,s chools and practices to keep track of their patients/students immunizations; DHSS/DHCQ - Delaware Department of Health and Social Services/Division of Health Care Quality; DO - doctor of osteopathy; DON - Director of Nursing; Foley catheter - Tube held in the bladder by a small balloon to drain urine; Ombudsman - Person who investigates resident complaints and helps to achieve agreement with the facility; IDT - interdisciplinary team; LPN - Licensed Practical Nurse; MD - Medical Doctor; MDS- Minimum Data Set; Meds - Medications; Minimum Data Set (MDS) - Standardized assessment forms used in nursing homes; MRR - Medication Regimen Review; Neurogenic bladder - lack of bladder control due to brain, spinal cord, or nerve condition; NHA - Nursing Home Administrator; NP - Nurse Practitioner; PRN - As needed; PT - Physical therapy; RN - Registered Nurse; Sacrum - Tailbone; Severe Cognitive Impairment - Unable to make own decisions; UM - Unit Manager Wound VAC - Negative pressure dressing to promote wound healing.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2)	F 550		8/9/24

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F 550	Continued From page 8 §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this	F 550		

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F 550	Continued From page 9 subpart. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, it was determined that for three (R18, R34 and R270) out of the survey sample of seventeen residents reviewed for resident rights, the facility failed to ensure that the residents had the right to a dignified existence. Findings include: 1. Review of R270's clinical record revealed: 6/19/24 - R270 was admitted to the facility with multiple diagnoses, including obstructive uropathy, and R270 had a foley catheter in place at admission. 6/25/24 - A review of R270's electronic medical record (EMR) revealed the presence of an admission care plan with interventions to care for R270's catheter, which included to place the catheter bag away from the entrance room door. The following observations were made on 6/24/24: 10:29 AM - An uncovered urinary catheter bag hanging on the right had side of the bed, visible from the entrance room door. 12:30 PM - An uncovered urinary catheter bag hanging on the right side of the bed, visible from the entrance door. The following observations were made on 6/25/24:	F 550	Corrective Action: "Corrective actions have been ensured by the Director of Nursing and Designee. "Resident R270, R34, and R47 have been provided an updated copy of the Residents Rights and informed of their right to privacy on 7/25/2024 by the Director of Nursing. "A catheter privacy bag was provided to R27, R34 and R 47□s catheter bags to on June 24, 2024 by E4. "These residents have been encouraged to notify the Administrator, Director of Nursing, or Social Worker if their rights are not honored at any time. "The care plan for R27, R34, and R47□s were reviewed by MDSC and revised to include catheter privacy bag to cover urine output. Identification of Other Residents: "Current residents with physician orders for a catheter have the potential to be affected. "Resident Rights will be reviewed in a Resident Council meeting to ensure that Residents know their rights and to verify that other residents have not experienced any concerns with their rights not being honored. "An audit of current residents was completed by the Clinical Specialist (E4) to identify current residents with Catheters.	

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F 550	Continued From page 10 10:30 AM -R270 was sitting in his wheelchair with the ¾ urine filled catheter bag hanging on the wheelchair, and which was visible from the doorway. 11:41 AM - R270 was observed sitting in his wheelchair in the doorway of his room, with an uncovered catheter bag hanging on the back of his wheelchair. Additionally, the CNA wheeled R270 to the shower room with the uncovered catheter bag dragging on the floor. 6/26/24 10:45 AM - The above 11:41 AM observations were confirmed with E3 (ADON) and E4 (Clinical Specialist). Findings were reviewed during the exit conference on 7/2/24 at 2:15 PM with E1 (NHA), E2 (DON), E3 (ADON), E4 (Clinical Specialist), and State of DE Ombudsmen (via telephone). 2. Review of R34's medical records revealed: 5/4/24 - R34 was admitted to the facility with diagnoses including neurogenic bladder. 5/10/24 - R34's clinical records documented, "Ensure that tubing and dignity bag are off the floor." 5/13/24 - R34's care plan included, "Privacy bag at all times." 6/24/24 10:30 AM - R34 was observed lying in the bed, an uncovered, an undated urinary collection bag with yellow urine was observed on the floor on the left side of the bed. 6/24/24 1:30 PM - R34 was observed lying in the	F 550	"Current residents identified with a physician order for a catheter were provided a catheter privacy bag. System Changes: "The Root Cause of the concern was the failure to accurately adhere to the required elements in the policy Residents Rights (revised 12.2016) and the policy for Dignity (rev. 2.2021). "The facility policy for Residents Rights (revised 12.2016) and Dignity (rev. 2.2021) were reviewed and found to meet professional standards. "The facility system for daily nursing management rounds has been updated to include monitoring of residents with catheters for privacy bag compliance. "The Director of Nursing or Designee will complete education for current staff on residents□ rights and dignity with a focus on maintaining a privacy bag over the resident's catheter. Success Evaluation: "An audit of current residents with catheters ordered was conducted to monitor compliance of privacy placement. "Routine monitoring of privacy bags covering catheters will be completed by the Director of Nursing or Designee; monitor will have a goal of 100% compliance; "Audits will be completed weekly until 100% compliance is achieved for 3 consecutive evaluations, then every other week until 100% compliance is achieved	

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F 550	Continued From page 11 bed, the uncovered, an undated urinary collection bag with yellow urine continued to be on the floor on the left side of the bed. 6/25/24 10:30 AM - R34 was observed lying in the bed, an uncovered, an undated urinary collection bag with yellow urine was observed on the right side of the bed on the floor. 6/25/24 2:30 PM - R34 was observed lying in the bed, an uncovered, the undated urinary bag with yellow urine continued to be observed on the right side of the bed on the floor. 3. Review of R47's clinical records revealed: 1/6/22 - R47 was admitted to the facility with diagnoses including neurogenic bladder. 5/10/23 - R47's clinical records documented, "Check tubing for kinks, and privacy bag at all times, secure catheter to reduce friction." 6/24/24 10:30 AM - R47 was observed lying in bed, an undated, uncovered urinary collection bag with yellow urine was observed touching the floor on the left side of the bed. 6/24/24 2:30 PM - R 47 was observed lying in bed, an undated, uncovered urinary collection bag with yellow urine continued to be touching the floor on the left side of the bed. 6/25/25 10:00 AM - R47 was observed lying in bed, an uncovered, undated urinary collection bag with yellow urine hanging on the right side of the bed and visible from the doorway. 6/25/24 2:30 PM - R47 was observed lying in bed,	F 550	for 3 consecutive evaluations, and then monthly until 100% compliance is achieved for 3 consecutive evaluations. "The results of the audits will be provided to the QAPI Committee by the DON/ADON monthly for the next 3 months to determine the need for continued monitoring.	

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	085031	A. BUILDING _____ B. WING _____	C 07/02/2024

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F 550	Continued From page 12 an uncovered, undated urinary collection bag with yellow urine in a wash basin was on the left side of the bed on the floor. 6/25/24 3:00 PM - Findings were confirmed with E3 (ADON) and E4 (Clinical Specialist). Findings were reviewed during the exit conference on 7/2/24 at 2:15 PM with E1 (NHA), E2 (DON) E3 (ADON), E4 (Clinical Specialist), E32 (Corporate PT) and State of DE Ombudsman (via telephone).	F 550		
F 553 SS=D	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. §483.10(c)(3) The facility shall inform the resident	F 553		8/9/24

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F 553	Continued From page 13 of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This REQUIREMENT is not met as evidenced by: 2. Review of R4's clinical record revealed: 1/21/24 - R4 was admitted to the facility. 1/23/24 - R4 participated in his Care Plan conference and signed his Care Plan Conference Summary dated 1/23/24. 4/26/24 - R4's quarterly Minimum Data Set (MDS) assessment was completed. The facility was not able to produce any documentation of R4 participating in any other Care Plan conferences. 6/28/24 12:20 PM - During an interview, E4 (Corporate CNS) stated, "The facility did not do a care plan meeting in April with [R4]. We are scheduling one ASAP. We did not update the care plan in April because we didn't have a care conference." 3. R13's clinical record revealed: 5/24/24 - R13 was admitted to the facility after being hospitalized. 5/30/24 - R13's admission MDS assessment	F 553	Corrective Action: "Resident R4 has been provided an updated copy of the Residents Rights and informed of their right to participate in the development of their Plan of Care. "The care plan was reviewed by the MDSC with the resident and updated as indicated to meet resident R4□s required care. The Care Plan is to include the resident□s preferences to ensure that resident rights and preferences are honored, and that the resident has had an opportunity to participate in the care planning process. "Resident R13□s POA was contacted by the DON and provided them with the current medication list. Identification of Other Residents: "Current residents have the potential to be affected. "Resident Rights were reviewed by the Activities Director at the Resident Council meeting. Residents were educated on their rights, including but not limited to participating in care planning.	

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F 553	Continued From page 14 stated that she had a moderate cognitive impairment. 6/7/24 at 6:47 PM - A physician's order by E5 (NP) discontinued R13's Flomax medication with a diagnosis incorrectly listed as benign prostatic hyperplasia (BPH). There was no evidence in R13's clinical record that F1 (R13's POA) was notified of this medication change. 6/9/24 at 6:45 PM - A physician's order by E5 (NP) discontinued R13's Primidone medication with a diagnosis incorrectly listed as depression. There was no evidence in R13's clinical record that F1 was notified of this medication change. 6/28/24 at 10:35 AM - During an interview, F1 confirmed that she was R13's Power of Attorney for Care. F1 confirmed that she was not notified that E5 (NP) discontinued R13's Flomax medication prescribed for urinary retention and the Primidone medication as F1 stated it was prescribed for R13's tremors. 6/28/24 at 11:30 AM - Finding was reviewed with E2 (DON) and E3 (ADON). 7/2/24 at 2:15 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (DON), E3 (ADON), E4 (Clinical Specialist) and two State of DE Ombudsmen (via telephone).	F 553	System Changes: "The Root Cause of the concern was the failure to accurately adhere to the required elements in the policy Care Plans, Comprehensive Person-Centered (Rev. 3.2022) and Residents Rights (revised 12.2016). These policies were reviewed and found to meet professional standards. "The facility system for managing the Care Planning process has been revised to include a monthly review of resident participation compliance in care planning in the monthly Quality Assurance and Performance Improvement (QAPI) committee meeting. "Current licensed direct care nurses were re-educated on the need to communicate order changes to the resident and/or responsible party by the Director of Nurses or Design. Success Evaluation: "An audit of a random sample of a minimum of 5 residents with care plan updates will be reviewed to monitor resident participation in the care planning process. "New resident orders will be monitored by the Unit Manager or Designee for communication to the resident or responsible party 3 x per week for the next 2 weeks, then 2 x per week for the next 2 weeks, then 1 time per week for the next 3 months. "Audits will be completed by Social Service Director or designee; Audits will	

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F 553	Continued From page 15	F 553	have a goal of 100% compliance; Audits will be completed weekly until 100% compliance is achieved for 3 consecutive evaluations, then every other week until 100% compliance is achieved for 3 consecutive evaluations, and then monthly until 100% compliance is achieved for 3 consecutive evaluations. "Additional audits will be completed as needed based upon the level of compliance. The results of the audits will be reviewed by the Quality Assurance Team. "The results of the audits will be provided to the QAPI Committee by the Social Service Director/Unit Manager monthly for the next 3 months to determine the need for continued monitoring.	
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that for three (R19, R33 and R45) residents reviewed, the facility failed to ensure that the call bells were within their reach on three observed occasions. Findings include: 1. Review of R19's medical records revealed: 4/2/2016 - R19 was admitted to the facility with	F 558	Corrective Action: "Corrective actions have been ensured by the Director of Nursing. Resident R19, R33, and R45 were assessed by the DON. With no physical change of condition noted. The Call light was within reach at the time of the assessment. "Resident R19. R33 and R45 were	8/9/24

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F 558	Continued From page 16 diagnoses including shortness of breath, asthma, and congestive heart failure. 517/24 - R19's significant change MDS assessment documented a BIMS score of 14 (fourteen), indicating no cognitive impairment. 6/24/24 10:15 AM - R19 was observed lying in bed. The bell was observed on the floor near the head of the bed. 6/24/24 11:30 AM - R19 was observed lying in bed. The call bell was observed on the floor near the head of the bed. 6/24/24 1:00 PM - R19 was observed lying in bed. The call bell continued to be on the floor near the head of the bed. 6/24/24 1:10 PM - The surveyor asked R19 if she used the call bell to let the staff know if she needed assistance, R19 stated, "Yes, where is my call bell?". 2. Review of R33's clinical records revealed: 11/30/23 - R33 was admitted to the facility with diagnoses including acute respiratory failure, congestive heart failure and chronic pain. 6/24/24 - R33's quarterly MDS assessment documented a BIMS score of 14, indicating no cognitive impairment. 6/24/24 10:30 AM - R33 was observed sitting in the wheelchair in her room. The call bell was observed lying on the floor behind the wheelchair. 6/24/24 12:30 PM - R33 was observed sitting in	F 558	monitored on daily rounds by various members of the IDT to ensure that the call light was within reach and functional. No observations were made of call light out of reach or non-functional. Identification of Other Residents: "Current residents have the potential to be affected. "To prevent other residents from being affected, current nursing staff members will be re-educated regarding the proper placement of a functioning call light to be within residents reach during time in residents' room in bed or chair. "Random resident observations to check that the call lights were functional and within reach were completed during morning IDT rounds. No observations of residents□ call lights were noted to be non-functional and/or out of residents□ reach. System Changes: "The Root Cause of the concern was the failure to accurately adhere to the required elements in the policy Call System, Resident (revised 9.2022). The policy was reviewed and found to meet professional standards. "The facility system for daily rounds has been updated to include a focus on monitoring residents' ability to reach their call light while in residents' room in the bed or chair and that it is functioning. Success Evaluation:	

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F 558	Continued From page 17 the wheelchair in her room. A CNA brought R33's lunch. The call bell was observed lying on the floor behind the wheelchair. 6/24/24 1:30 PM - R33's call bell continued to be on the floor behind the wheelchair. 6/24/24 1:45 PM - The surveyor asked R33 if she used the call bell to let the staff know if she needed assistance, R33 stated, "Yes". 3. Review of R45's clinical records revealed: 6/23/23 - R45 was admitted to the facility with diagnoses including heart disease, depression, dementia, and muscle weakness. 6/21/24 - R45's annual MDS assessment documented a BIMS score of 00, indicating severe cognitive impairment. 6/24/24 10:35 AM - R45 was observed lying on the bed. The call bell was on the floor behind the bed. 6/24/24 11:35 AM - R45 was observed lying on the bed. The call bell was on the floor behind the bed. 6/24/24 1:35 PM - R45 observed lying on the bed. The call bell continued to be on the floor behind the bed. 6/24/24 1:50 PM - The surveyor asked R45 if she used the call bell to get the staff's assistance, R45 stated, "Yes". 6/24/24 2:00 PM - Findings were confirmed with E3 (ADON).	F 558	"An audit of a random sample of a minimum of 10 residents will be observed to confirm that their call light is within reach and functioning; "Random audits will be completed by the Director of Nursing or Designee; Audits will have a goal of 100% compliance; Audits will be completed weekly until 100% compliance is achieved for 3 consecutive evaluations, then every other week until 100% compliance is achieved for 3 consecutive evaluations, and then monthly until 100% compliance is achieved for 3 consecutive evaluations. "The results of the audits will be provided to the QAPI Committee by the DON/ADON or Designee monthly for the next 3 months to determine the need for continued monitoring.	

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F 558	Continued From page 18 Findings were reviewed during the exit conference on 7/2/24 at 2:15 PM with E1 (NHA), E2 (DON) E3 (ADON), E4 (Clinical Specialist), E32 (Corporate PT) and State of DE Ombudsman (via telephone).	F 558		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(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	F 609		8/9/24

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F 609	Continued From page 19 by: F609 Report Allegation of Abuse- Based on record review and Interviews, it was determined that for one (R28) out of two residents reviewed for Abuse, the facility failed to report R28's allegation of abuse within the two hour time frame. Findings include: 10/15/16 - R28 was admitted to the facility. 12/28/23- R28's quarterly MDS assessment documented a BIMS score of 7, which was reflective of moderate cognitive deficit. 1/23/24 6:30 PM - While providing care to R28, E37 (CNA) noted a left forearm skin tear, which E37 reported to E38 (LPN). 1/24/24 - While investigating R28's left forearm skin tear of unknown origin, R28 stated that the CAN hurt her (causing the skin tear) and she (R28) doesn't know why the CAN wants to hurt her. 1/24/24 - R28 was care planned for making false accusations. 1/24/24 4:12 PM - The allegation of abuse was reported to the State agency. This allegation of abuse was reported to the State agency twenty-two hours after the incident was brough to the attention of facility staff. 6/28/24 10:48 AM - During an interview, E3 (ADON) stated, "The reason it was not reported until late was that [E38] (LPN) did not report the allegation to management until 1/24/24. She was counseled in writing and educated about reporting	F 609	Corrective Actions: · There is no opportunity to correct the reporting for Resident R28. · A skin assessment was completed on Resident R28 on June 27, 2024 by the nurse. No other skin impairments were noted. · Associate E38 was re-educated on the protocol to report allegations of abuse within two hours of the occurrence. Identification of Other Residents: · Current residents have the potential to be affected. · In order to prevent a recurrence, current associates were provided re-education on Abuse Prevention and Reporting, including the time for reporting requirements by the DON or Designee. System Changes: · The Root Cause of the concern was a failure to adhere to the facility policy for "Abuse, Neglect, Exploitation or Misappropriation – Reporting and Investigating" (rev. 9.2022). The facility policy for "Abuse, Neglect, Exploitation or Misappropriation – Reporting and Investigating" (rev. 9.2022) was reviewed and found to meet professional standards. · The facility system for reporting abuse	

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F 609	Continued From page 20 all allegations of abuse immediately." Findings were reviewed during the exit conference on 7/2/24 at 2:15 PM with E1 (NHA), E2 (DON), E3 (ADON), E4 (Clinical Specialist) and two State of DE Ombudsmen (via telephone).	F 609	concerns has been revised to include a monthly review of compliance in the monthly Quality Assurance and Performance Improvement (QAPI) committee meeting. The administrator and the nursing management team will provide oversight to ensure ongoing compliance. · Reported skin tears on current residents will be reviewed by the Director of Nursing or Designee to determine the root-cause of the injury to determine no indication of potential resident abuse. Success Evaluation: · An abuse reporting audit was completed to monitor compliance with reporting requirements will be completed by the Administrator or designee on all reports of potential abuse weekly; Audits will have a goal of 100% compliance; Audits will be completed weekly until 100% compliance is achieved for 3 consecutive evaluations, then every other week until 100% compliance is achieved for 3 consecutive evaluations, and then monthly until 100% compliance is achieved for 3 consecutive evaluations. · The results of the audits will be provided to the QAPI Committee by the DON/ADON or Designee monthly for the next 3 months to determine the need for continued monitoring.	
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8)	F 623		8/9/24

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F 623	Continued From page 21 §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or	F 623		

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F 623	Continued From page 22 (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice.	F 623		

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F 623	Continued From page 23 If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R5) out of one resident reviewed for hospitalization, the facility failed to notify the resident and the resident's representative in writing of R5's transfer to the hospital, including the reason for the transfer. Findings include: Review of R5's clinical record revealed: 6/13/23 - R5 was admitted to the facility. 5/15/24 - R5 was transferred to the hospital because of chest pain. R5 was admitted to the hospital and was discharged back to the facility on 5/21/24. 6/27/24 2:20 PM - During an interview, E3 stated that the facility's process for hospital transfer communications is to provide verbal communication to resident representatives when	F 623	Corrective Action: "Resident R5 was re-admitted to the community on May 21, 2024. No transfers to the hospital since the date of the most recent admission. Notice of transfer was not provided in writing as to why R5 was transferred to the hospital on May 15, 2024. Identification of Other Residents: "Current residents have the potential to be affected. "In order to prevent other residents from being affected, current licensed nurses and Director of Social Services will be re-educated on the requirement to provide notice of transfer or discharge to the responsible party. Notifications as to the reason for transfer to the hospital have been provided to the POA or responsible party in writing by the DON or designee.	

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F 623	Continued From page 24 residents are transferred to the hospital, not written communication. R5's representative would not have received written communication related to E5's 5/15/24 transfer. Findings were reviewed during the exit conference on 7/2/24 at 2:15 PM with E1 (NHA), E2 (DON), E3 (ADON), E4 (Clinical Specialist), and State of DE Ombudsmen (via telephone).	F 623	System Changes: "The Root Cause of the concern was the failure to adhere to the required elements in the policy Transfer or Discharge Notice (revised 12.2016). The facility policy Transfer or Discharge Notice (revised 12.2016) was reviewed and found to meet professional standards. The facility system for daily clinical review meeting has been updated to include a review of all transfers and discharges to confirm compliance of notification has been provided to the responsible party. "The Director of Nursing or Designee will complete education for current licensed nurses and social services staff regarding the requirement to provide notice of transfer or discharge to the responsible party. Success Evaluation: "A 100% audit of all discharges and transfers in the last 30 days has been completed to confirm responsible party notification. "Subsequent audits of all discharges in the previous 7 days will be completed by the Director of Nursing or Designee to confirm notification has been provided to the responsible party; Audits will have a goal of 100% compliance; Audits will be completed weekly until 100% compliance is achieved for 3 consecutive evaluations, then every other week until 100% compliance is achieved for 3 consecutive evaluations, and then monthly until 100%	

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F 623	Continued From page 25	F 623	compliance is achieved for 3 consecutive evaluations. "The results of the audits will be provided to the QAPI Committee by the DON or Designee monthly for the next 3 months to determine the need for continued monitoring.	
F 638 SS=D	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, it was determined that for one (R44) out of seventeen reviewed for Resident Assessments, the facility failed to assess R44 no less than once every three months. Findings include: 11/14/23 - R44 was admitted to the facility. 1/3/24 - R44's admission Minimum Data Set (MDS) assessment was completed. 1/29/24 - R44 was hospitalized. 1/30/24 - R44 was re-admitted to the facility. 2/6/24 - R44's admission MDS was completed. As of 6/26/24, there were no other MDS assessments completed for R44. There has been more than 141 days since the last MDS assessment.	F 638	Corrective Action: "There is no opportunity for correction of the timeliness of the MDS for resident R44. "An updated MDS assessment was completed for R44 on July 10, 2024 by the MDSC. "The MDS nurses have been re-educated on the requirements for ensuring assessment timeliness and completion at least every 3 months by the MDSC Identification of Other Residents: "Current residents have the potential to be affected. "An audit of current residents MDS assessment was completed by MDSC to confirm MDS compliance within the last 3 months.	8/9/24

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F 638	Continued From page 26 6/27/24 1:26 PM - During an interview, E33 (MDS coordinator) confirmed that R44 was past due for a quarterly MDS assessment. E33 stated, "I'm not sure why the system did not flag him." Findings were reviewed during the exit conference on 7/2/24 at 2:15 PM with E1 (NHA), E2 (DON), E3 (ADON), E4 (Clinical Specialist) and two State of DE Ombudsmen (via telephone).	F 638	System Changes: "The Root Cause of the concern was the failure to complete an MDS assessment for R44 at least every 3 months. The facility policy for Comprehensive Assessments and the Care Delivery Process (revised 12.2016) was reviewed and found to meet professional standards. "The Director of Nursing or Designee will complete education for all nursing staff, including the MDS nurses, on the requirements for MDS assessment frequency. "The Administrator will monitor the compliance of MDS assessments weekly for the next 4 weeks, then monthly for the next 3 months. Success Evaluation: "An audit of a random sample of 10 of residents will be completed by the Administrator or Designee to confirm an MDS assessment has been completed at least within the last three months on current residents; "Audits will have a goal of 100% compliance; Audits will be completed weekly until 100% compliance is achieved for 3 consecutive evaluations, then every other week until 100% compliance is achieved for 3 consecutive evaluations, and then monthly until 100% compliance is achieved for 3 consecutive evaluations. "The results of the audits will be provided to the QAPI Committee by the MDSC monthly for the next 3 months to	

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F 638	Continued From page 27	F 638	determine the need for continued monitoring.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for two (R21, R22) out of seventeen residents reviewed for Resident Assessments, the facility failed to ensure accuracy of the assessments. Findings include: 1. Review of R21's clinical record revealed: 8/10/19 - R21 was admitted to the facility with diagnoses, including but not limited to, Parkinsonism, epilepsy and hypertension. 5/3/24 - R21's quarterly Minimum Data Set (MDS) assessment was completed and failed to document in Section I Parkinson's disease as one of R21's diagnoses. 6/27/24 1:21 PM - During an interview, E33 (MDS Coordinator) confirmed that the diagnosis of Parkinson's was not in R21's MDS dated 5/3/24 and that it should have been included. 2. Review of R22's clinical record revealed: 4/27/21 - R22 was admitted to the facility with diagnoses, including but not limited to, atrial fibrillation, heart failure and dementia.	F 641	Corrective Action: "There is an opportunity for correction of the MDS for resident R21 or R22. MDS modifications are in process to correct the inaccurate coding of diagnoses. "The MDS nurses were educated on June 27, 2024 by the MDS Specialist on the requirements for ensuring assessment accuracy. Identification of Other Residents: "Current residents have the potential to be affected. "Current residents will be identified by ensuring that the most recent assessment for all current residents is current diagnosis. "An audit of the most recent MDS assessment for current residents will be audited by the MDS Coordinators to confirm residents' current diagnosis was accurately coded. System Changes: "The Root Cause of the concern was the	8/9/24

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F 641	Continued From page 28 5/1/24 R22's annual MDS assessment was completed and documented in Section I pneumonia as one of R22's active diagnoses. The facility was unable to produce evidence that verified coding pneumonia as an active diagnosis for R22 as there was no evidence of this diagnosis in R22's chart for this quarter. 6/28/24 12:06 PM - During an interview, E4 (Clinical Specialist) stated, "The pneumonia documented on the 5/1/24 MDS was a mistake. [R22] did not have pneumonia during that period of time. We are fixing the MDS and resubmitting it." Findings were reviewed during the exit conference on 7/2/24 at 2:15 PM with E1 (NHA), E2 (DON), E3 (ADON), E4 (Clinical Specialist) and two State of DE Ombudsmen (via telephone).	F 641	failure to accurately complete the MDS assessment for R21 and R22. The facility policy for Comprehensive Assessments and the Care Delivery Process (revised 12.2016) and MDS Error Correction (9.2010) were reviewed and found to meet professional standards. "The Director of Nursing or Designee will complete education for the MDS nurses, on the requirements for resident diagnosis coding to be accurate. "A review of clinical diagnosis will be completed by the Interdisciplinary Team weekly at the Med A meeting for the next 4 weeks. Then monthly for the next 3 months. Success Evaluation: "An audit of a random sample of 10% of resident MDS assessments will be completed by the Director of Nursing or Designee to ensure MDS assessment accuracy; audits will have a goal of 100% compliance; "Audits will be completed weekly until 100% compliance is achieved for 3 consecutive evaluations, then every other week until 100% compliance is achieved for 3 consecutive evaluations, and then monthly until 100% compliance is achieved for 3 consecutive evaluations. "The results of the audits will be provided to the QAPI Committee by the MDSC monthly for the next 3 months to determine the need for continued monitoring.	
F 645 SS=D	PASARR Screening for MD & ID	F 645		8/9/24

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F 645	Continued From page 29 CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission	F 645		

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F 645	Continued From page 30 to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R62) out of two reviewed for PASARR, the facility failed to secure R62's PASARR upon admission on 4/8/24. Findings include: 4/8/24 - R62 was admitted to the facility with diagnoses including Parkinson's, diabetes and bipolar disorder.	F 645	Corrective Action: "The PASARR was updated for Resident R62 by the Director of Nursing on July 2, 2024. Identification of Other Residents: "Current residents have the potential to be	

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F 645	Continued From page 31 4/21/24 - R62's Minimum Data Set (MDS) assessment documented bipolar disorder as one of R62's diagnoses in Section I. 6/27/24 1:30 PM - During an interview, E2 (DON) stated, "We haven't been able to locate that PASARR. We are looking. R62 came here from an AL (Assisted Living) community." 6/28/24 8:52 AM - During an interview, E2 stated, "We still have not been able to find her (R62's) PASARR. I am going to request it online again and see if they will send me a duplicate." 7/2/24 2:10 PM - E2 confirmed that the facility has not located R62's PASARR document. Findings were reviewed during the exit conference on 7/2/24 at 2:15 PM with E1 (NHA), E2 (DON), E3 (ADON), E4 (Clinical Specialist) and two State of DE Ombudsmen (via telephone).	F 645	affected. In order to ensure that other residents are not affected the community will monitor any admissions for which a PASARR is required. · A 100% audit of all newly admitted residents to confirm the PASARR requirements for completion and updates were within compliance by the IDT team. Current resident PASARRs are within compliance System Changes: "The Root Cause of the concern was a failure to adhere to the facility policy for Behavioral Assessment, Intervention and Monitoring (rev. 3.2019) and to update the PASARR as required. The facility policy for Behavioral Assessment, Intervention and Monitoring (rev. 3.2019) was reviewed and found to meet professional standards. "The facility system for the monthly Behavior Management meeting has been updated to include a discussion of PASARR update needs based on changes in resident status, new psychological diagnoses, or new psychoactive medications. "The Director of Nursing or Designee will complete education for current licensed nurses and social services staff regarding the policy for the requirements for PASARR completion and updates. "In order to prevent other residents from being affected, current licensed nurses and social services staff members will be	

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F 645	Continued From page 32	F 645	re-educated on the requirements for PASARR completion and updates. Success Evaluation: "A 100% audit of all current residents to ensure that the PASARR requirements for completion and updates have been met has been completed to ensure an up-to-date PASARR as needed. "Subsequent audits of a random sample of a minimum of 5 residents will be completed by the Admission Coordinator or Designee to ensure that the PASARR requirements for completion and updates have been met; Audits will have a goal of 100% compliance; Audits will be completed weekly until 100% compliance is achieved for 3 consecutive evaluations, then every other week until 100% compliance is achieved for 3 consecutive evaluations, and then monthly until 100% compliance is achieved for 3 consecutive evaluations. "The results of the audits will be provided to the QAPI Committee by the Admissions Coordinator monthly for the next 3 months to determine the need for continued monitoring.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §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	F 656		8/9/24

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F 656	Continued From page 33 objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed.	F 656		

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F 656	Continued From page 34 This REQUIREMENT is not met as evidenced by: Based on record review and interviews, it was determined that for two (R54 and R172) out of four reviewed for care plans, the facility failed to develop and implement a person-centered care plan. Findings include: 1. Review of R54's clinical record revealed: 5/16/23 - R54 was admitted to the facility with diagnoses, including but not limited to, multiple sclerosis and stroke affecting R54's right side. 5/22/24 - E36 (DO) ordered, "Apply resting hand splint to righthand at the end of 3-11 shift and remove at the end of 11-7 shift". Review of R54's care plan revealed no interventions/tasks regarding R54's righthand splint. The facility was not able to produce any documentation of the righthand splint on R54's care plan. 6/28/24 8:55 AM - During an interview, E2 (DON) confirmed that R54's care plan did not include any mention of R54's righthand splint. "We can add it into the care plan if that is what we need to do." 2. Review of R172's clinical records revealed: 11/14/21 - R172 was admitted to the facility. 1/24/24 - R172's quarterly MDS assessment documented that the resident was completely dependent on staff for all activities of daily living	F 656	Corrective Action: "A care plan meeting was held with Resident R54 to confirm compliance of the current care plan is up to date and person-centered. "There is no opportunity for correction for R172 because she is no longer a resident in our facility. Identification of Other Residents: "Current residents have the potential to be affected. "In order to prevent other residents from being affected, Current nursing and social services staff members will be re-educated on the requirements of the Comprehensive Care Plan, as well as the requirements to develop a person-centered care plan. "A 100% audit of current resident care plans will be completed by the Director of Social Services or Designee to confirm each resident has had the opportunity to participate in developing their care plan to confirm the interventions are person-centered. System Changes: "The Root Cause of the concern was a failure to follow the policy for Care Plans, Comprehensive Person-Centered (rev. 12.2016) and complete, update, and comply with person-centered Comprehensive Care Plan development	

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F 656	Continued From page 35 including turning, repositioning, showers, and transfers. R172's BIMS score was 6, which indicated severe cognitive impairment. 7/1/24 9:20 AM - A review of R172's Kardex (electronic document for the aides to inform the staff of the residents' care needs) lacked information of how many staff members were needed to assist with turning and repositioning in bed. A review of R172's care plan also lacked documentation of how many staff members were needed for turning and repositioning in bed. 7/1/24 1:15 PM - During an interview, E5 (Unit Manager) stated, "Physical Therapy determines how many staff members are needed for transfers and turning and repositioning. This information is then communicated to nursing, the order is obtained from the doctor, and the Kardex and the care plan are updated." 7/1/24 2:17 PM - During an interview, E6 (Physical Therapy Director) stated, "The residents are seen on admission and evaluated for bed mobility and transfer status. This information is given to nursing for the resident's records". E6 failed to give the surveyor any documents of R172's evaluation and recommendations for bed mobility upon request. 7/1/24 2:30 PM - During an interview, E14 and E19 (CNAs), stated that they look at the Kardex for information on residents' care including bed mobility and transfers. The facility failed to evaluate and develop a care plan for how many staff members were needed for R172's turning and repositioning, and that this information was documented on the Kardex	F 656	and implementation requirements for Resident R54 and R172. The facility policy for Care Plans, Comprehensive Person-Centered (rev. 12.2016) was reviewed and found to meet professional standards. "The facility system for the weekly Residents at Risk review meeting has been updated to include a discussion of the Comprehensive Care Plan for current residents admitted within the last 30 days. Current residents due for a quarterly or significant change MDS assessment, and other residents identified as at risk, to ensure that the Care Plan is up to date and identified interventions are in place and person-centered. "Current resident care plan updates with the MDS Assessment schedule will include resident participation to confirm person-centered care planning. "The Director of Nursing or Designee will complete education for current nursing and social services staff regarding the policy for Comprehensive Care Plans. Success Evaluation: "An initial 100% audit of current resident care plans has been completed to confirm that the Care Plan is up to date and has been revised appropriately within the last quarter or since significant change to reflect person-centered care interventions. Subsequent audits of a random sample of a minimum of 10% of residents Care Plans will be completed by the Director of Nursing or Designee to confirm that the Care Plan is up to date and reflect	

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F 656	Continued From page 36 status for staff to care for her safely. Findings were reviewed during the exit conference on 7/2/24 at 2:15 PM with E1 (NHA), E2 (DON) E3 (ADON), E4 (Clinical Specialist), E32 (Corporate PT) and State of DE Ombudsman (via telephone).	F 656	person-centered care interventions; "Audits will have a goal of 100% compliance; Audits will be completed weekly until 100% compliance is achieved for 3 consecutive evaluations, then every other week until 100% compliance is achieved for 3 consecutive evaluations, and then monthly until 100% compliance is achieved for 3 consecutive evaluations. "The results of the audits will be provided to the QAPI Committee by the Director of Social Services monthly for the next 3 months to determine the need for continued monitoring.	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in	F 657		8/9/24

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F 657	Continued From page 37 disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R5) out of one resident reviewed for care planning, the facility interdisciplinary team failed to review and revise R5's care plan after a comprehensive assessment was completed. Findings include: Review of R5's clinical record revealed: 6/13/23 - R5 was admitted to the facility. 5/28/24 - A Minimum Data Set (MDS) comprehensive assessment was documented for R5, which included a newly assessed care area for dehydration. 6/13/24 - A care plan meeting was held with the interdisciplinary team to review R5's care needs. 6/25/24 - A review of R5's electronic medical record (Emr) care plan revealed the lack of a care plan problem for dehydration. 6/28/24 10:40 AM - During an interview, E33 (MDS Coordinator) confirmed that dehydration was a new care area identified for R5, but that R5's care plan lacked a problem for dehydration after the care plan meeting was held on 6/13/24. Findings were reviewed during the exit conference on 7/2/24 at 2:15 PM with E1 (NHA),	F 657	Corrective Action: "Corrective actions have been ensured by the MDSC to have the appropriate patient-centered Care Plans in place when a change in condition has been identified. Identification of Other Residents: "Current Residents have the potential to be affected. "In order to prevent other residents from being affected, current licensed nursing and social services staff members will be re-educated on the requirements of the Comprehensive Care Plan and compliance with Care Plan Revisions. "A 100% audit of current resident care plans was conducted to confirm identified that problems/diagnosis are care planned. System Changes: "The Root Cause of the concern was a failure to follow the policy for Care Plans, Comprehensive Person-Centered (rev. 12.2016) and complete, update, and comply with Care Plan revisions requirements for Resident R5, R223 & R270. The facility policy for Care Plans,	

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F 657	Continued From page 38 E2 (DON), E3 (ADON), E4 (Clinical Specialist), and State of DE Ombudsmen (via telephone).	F 657	Comprehensive Person-Centered (rev. 12.2016) was reviewed and found to meet professional standards. "The facility system for the weekly Residents at Risk review meeting has been updated to include a discussion of the Comprehensive Care Plan for all residents admitted within the last 30 days, current residents due for a quarterly or significant change MDS assessment, and other residents identified as at risk, to confirm the Care Plan is up to date and identified interventions are in place. "The Director of Nursing or Designee will complete education for current nursing and social services staff regarding the policy for Comprehensive Care Plans. Success Evaluation: "An initial 100% audit of current resident care plans has been completed to confirm the Care Plan is up to date and has been revised appropriately within the last quarter or since significant change. "Subsequent audits of a random sample of a minimum of 10% of residents Care Plans will be completed by the Director of Nursing or Designee to confirm the Care Plan is up to date and that the Advanced Directive care plan has been revised to indicate the resident wishes for their advanced directives; Audits will have a goal of 100% compliance; Audits will be completed weekly until 100% compliance is achieved for 3 consecutive evaluations, then every other week until 100% compliance is achieved for 3 consecutive evaluations, and then monthly until 100%	

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F 657	Continued From page 39	F 657	compliance is achieved for 3 consecutive evaluations. "The results of the audits will be provided to the QAPI Committee by the MDS monthly of the next 3 months to determine the need for continued monitoring.	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on clinical record review and interview, it was determined that for three (R5, R223 and R270) out of twenty-one residents reviewed for care planning, the facility failed to meet professional standards of the Delaware Board of Nursing Scope of Practice by having LPNs complete the admission assessment and admission progress note. Findings include: Delaware State Board of Nursing - RN, LPN and NA/UAP Duties 2024 ... Admission Assessments * - RN ... *= Once a care plan is established, the LPN may do assessments ...". The Braden Scale is a validated tool designed to assess a patient's risk of developing pressure ulcers. National Library of Medicine, Nov. 21, 2022. 1. Review of R5's clinical record revealed:	F 658	Corrective Action: "Corrective actions have been ensured by the Director of Nursing. Moving forward all admission assessments and admission notes will be completed by an RN. Identification of Other Residents: "Current Residents have the potential to be affected. "In order to prevent other residents from being affected, current nursing staff members will be re-educated related to the Delaware state requirements that a Registered Nurse must complete admission assessments. " A 100% audit of current new admissions will be conducted to confirm a Registered Nurse is completing the admission assessments.	8/9/24

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F 658	Continued From page 40 6/13/23 - R5 was admitted to the facility. A review of the clinical record revealed the following 6/13/23 facility admission assessments conducted by E38 (LPN): Wander Risk Evaluation, Pain evaluation, Bladder and Bowel Continence evaluation, Trauma Informed Screening, Functional Abilities and Goals-Admission, Baseline Care Plan, Braden (scale for predicting pressure ulcer risk) evaluation and a Skin and Wound-Total Body Skin Assessment. The admission progress note was completed by E37 (LPN). 2. Review of R270's clinical record revealed: 6/19/24 - R270 was admitted to the facility. A review of the clinical record revealed the following 6/19/24 facility admission assessments conducted by E39 (LPN): Elopement Evaluation, Fall Risk Evaluation, Functional Abilities and Goals-Admission, Baseline Care Plan, Braden (scale for predicting pressure ulcer risk) evaluation, Clinical Admission and the admission progress note. 6/22/24 - R223 was admitted to the facility. A review of the clinical record revealed the following 6/22/24 facility admission assessments conducted by E12 (LPN) and E39 (LPN): Dehydration Risk Evaluation, Elopement Risk Evaluation, Fall Risk Evaluation, Braden (scale for predicting pressure ulcer risk) evaluation, Functional Abilities and Goals-Admission, Baseline Care Plan, Clinical Admission. The admission progress note was written by E39.	F 658	System Changes: "The Root Cause of the concern was a failure to follow the State of Delaware, Board of Nursing Scope of Practice. "The Director of Nursing or Designee will complete education for current nursing staff related to the Admission Evaluation completion process. "The nurse leadership will coordinate new admission assessments to be completed by a registered nurse. Success Evaluation: "An initial 100% audit of all new admissions will be completed to confirm a registered nurse completes admission assessments. "Subsequent audits of new admissions will be completed by the Director of Nursing or Designee to confirm admission assessments are completed by a registered nurse. "Audits will have a goal of 100% compliance; Audits will be completed weekly until 100% compliance is achieved for 3 consecutive evaluations, then every other week until 100% compliance is achieved for 3 consecutive evaluations, and then monthly until 100% compliance is achieved for 3 consecutive evaluations. "The results of the audits will be provided to the QAPI Committee by the DON/designee, monthly for the next 3 months to determine the need for continued monitoring	

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F 658	Continued From page 41 7/1/24 - 2:35 PM - During an interview, E3 (ADON) confirmed that LPN's do admission assessments on new residents. Findings were reviewed during the exit conference on 7/2/24 at 2:15 PM with E1 (NHA), E2 (DON), E3 (ADON), E4 (Clinical Specialist), and State of DE Ombudsmen (via telephone).	F 658		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that for 1 (R45) resident out of 2 (two) reviewed for ADLs, the facility failed to ensure that R45 received appropriate care to maintain good grooming. Findings include: Review of R45's clinical records revealed: 6/23/23 - R45 was admitted to the facility with diagnoses including heart disease and muscle weakness. 7/28/23 - R45's care plan documented, " ...Please check my nail length, clean and trim on bath day and as necessary ..." 6/21/24 - R45's annual MDS assessment documented a BIMS of 00, indicating severe cognitive impairment, and was dependent on staff for bathing, grooming and hygiene.	F 677	Corrective Action: "The Care Plan for Resident R45 has been reviewed and it includes the intervention to Please check my nail length and trim and clean on bath day and as necessary. Report any changes to the nurse "R45□s nails were cleaned and trimmed by the CNA assigned to her on June 27, 2024. Identification of Other Residents: "Current Residents have the potential to be affected. "In order to prevent other residents from being affected, current nursing staff members will be re-educated by the Director of Nursing or Designee on the cleaning and care of residents' nails.	8/9/24

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F 677	Continued From page 42 6/24/24 10:30 AM - R45 was observed in bed, her fingernails on both hands were long and dirty. 6/24/24 12:30 PM - R45 was observed feeding herself with a fork. R45's fingernails continued to be long and dirty. 6/25/24 10:00 AM - R45 was observed with long, dirty fingernails on both hands on both hands. 6/26/24 8:30 AM - R45 was observed feeding herself with a fork, then picked up an item and put it in her mouth. Her fingernails continued to be long and dirty on both of her hands. The surveyor asked R45 if she would accept having her nails cleaned and trimmed, R45 stated, "Yes". 6/26/24 2:30 PM - Findings were confirmed with E3 (ADON) and E4 (Clinical Specialist). Findings were reviewed during the exit conference on 7/2/24 at 2:15 PM with E1 (NHA), E2 (DON) E3 (ADON), E4 (Clinical Specialist), E32 (Corporate PT) and State of DE Ombudsman (via telephone).	F 677	System Changes: "The Root Cause of the concern was a failure to provide adequate Activities of Daily Living (ADL) assistance to Resident R45. The facility policy for Activities of Daily Living (ADL), Supporting (3.2018) was reviewed and found to meet professional standards. "A visual review of current residents□ nails condition was completed by the Director of Nurses or Designee on June 27, 2024. Nail care was provided to residents as indicated. "The facility system for daily management rounds has been updated to include a focus on ensuring residents have nail care routinely. Success Evaluation: "A nail care documentation audit to confirm routine nail care assistance will be completed by the Director of Nursing or designee on a random sample of 10% of residents; "Audits will have a goal of 100% compliance; Audits will be completed daily until 100% compliance is achieved for 3 consecutive evaluations, then 3 times a week until 100% compliance is achieved for 3 consecutive evaluations, then weekly until 100% compliance is achieved for 3 consecutive evaluations, and then monthly until 100% compliance is achieved for 3 consecutive evaluations. "The results of the audits will be provided to the QAPI Committee by the Activities Director monthly for the next 3 months to	

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F 677	Continued From page 43	F 677	determine the need for continued monitoring	
F 685 SS=D	Treatment/Devices to Maintain Hearing/Vision CFR(s): 483.25(a)(1)(2) §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, it was determined that for one (R4) out of one reviewed for Communication-Sensory, the facility failed to ensure R4 received proper treatment to assist/ maintain hearing abilities as evidenced by not submitting a referral for a hearing consult despite R4 being severely hard of hearing. Findings include: 1/21/24 - R4 was admitted to the facility. 1/21/24 - E36 (DO) ordered in R4's electronic medical record (EMR), "May have dental, podiatry, ophthalmology, audiology consult." 6/24/24 5:20 PM - During an interview, R4 stated, "You have to speak in my right ear; that is the good one. I have difficulty hearing. I think it is wax	F 685	Corrective Action: "R4 was seen by the NP on June 28, 2024. Debrox was ordered. R4 was seen by ENT on July 20, 2024. Treatment rendered. "Current nursing staff members will be re-educated regarding the requirement that residents receive the necessary treatment/devices to maintain hearing. Identification of Other Residents: "Current Residents that are hard of hearing have the potential to be affected. "In order to prevent other residents from being affected, current nursing staff members will be re-educated regarding	8/9/24

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F 685	Continued From page 44 buildup but I would like to have my hearing checked." 6/27/24 10:40 AM - During an interview, E26 (LPN) stated, "[R4] has really bad hearing. That is why we keep his door closed because he blasts the volume on his TV and it bothers the other residents." 6/28/24 9:42 AM - During an interview, when asked about R4's hearing E35 (CNA) stated, "Oh that is him. He has always been hard of hearing. That is why his TV is on the max (volume) and his door (to his room) is kept shut, because his TV is so loud." The facility was unable to produce any documentation regarding treatment or a referral for R4's hearing deficit. 6/28/24 10:41 AM - During an interview, E32 (Corporate PT) stated, "We'll put him on the list for Audiology. Not sure if it is a carve out (sic) but we won't base it on his insurance. He may just need an amplifier." Findings were reviewed during the exit conference on 7/2/24 at 2:15 PM with E1 (NHA), E2 (DON), E3 (ADON), E4 (Clinical Specialist) and two State of DE Ombudsmen (via telephone).	F 685	the requirement that all residents receive the necessary treatment/devices to maintain hearing. System Changes: "The Root Cause of the concern was the failure ensure that Resident R4 received appropriate treatment and interventions to maintain sensory function. "The facility system for daily management rounds has been updated to include a focus on monitoring for current residents identified as hard of hearing, have been referred or seen for a hearing consult within the past year. "The monthly QAPI review process was updated to include a review of the list of residents identified as hard of hearing to be referred to an audiologist. Success Evaluation: "An audit of a random sample of a minimum of 10 residents will be observed to ensure that any sensory assistive devices hearing aides are in use, and that they have been referred to an audiologist within the previous year. "Audits will be completed by the Director of Nursing or Designee; Audits will have a goal of 100% compliance; Audits will be completed weekly until 100% compliance is achieved for 3 consecutive evaluations, then every other week until 100% compliance is achieved for 3 consecutive evaluations, and then monthly until 100% compliance is achieved for 3 consecutive evaluations.	

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F 685	Continued From page 45	F 685	"The results of the audits will be provided to the QAPI Committee by the DON/ADON or Designee monthly for the next 3 months to determine the need for continued monitoring	
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, and interviews, it was determined that for one (R172) out of two residents reviewed for accidents, the facility failed to ensure adequate supervision was provided to prevent accidents. This failure caused R172 to roll out of the bed while one staff member was providing care. R172 sustained harm, an injury to the back of the head and fractures to her left leg. Findings include: Review of R172's clinical records revealed: 11/14/21 - R172 was admitted to the facility with diagnoses including breast cancer, dementia, heart failure, depression. 11/21/21 - An order for a low air loss mattress (for wound pressure relief). 12/13/21 12:26 PM - A nursing progress note	F 689	Corrective Action: ¿ There is no opportunity for correction regarding the accident for resident R172. ¿ Nursing personnel will be educated regarding the proper positioning and turning technique when a dependent resident is on an air mattress. ¿ Nursing personnel will be educated about communicating the appropriate level of assistance required for bed mobility with direct care staff to ensure adequate supervision to prevent injury/fall. Identification of Other Residents: . All Residents have the potential to be affected. A 100% audit of all residents□ level of assist required for bed mobility has been completed to ensure safety	8/23/24

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F 689	Continued From page 46 documented, "Resident with a new stage 3 (three) wound to the sacrum ..." 12/20/22 3:27 PM - A nursing progress note documented, " ...Continued to be followed by wound care to due to stage 4 (four) to sacrum ...low air loss mattress in place." 2/26/23 2:30 AM - A review of the facility incident report revealed that she fell from the bed to the floor and sustained a left leg fracture. This fall was reviewed by the facility's interdisciplinary team, and a care plan to provide a safe environment, and fall mats to both sides of the bed were added. 1/24/24 - R172's quarterly MDS assessment documented that the resident was completely dependent on staff for all activities of daily living including turning, repositioning, showers, and transfers. R172's BIMS assessment score was 6, which indicated severe cognitive impairment. 3/15/24 2:00 PM - A facility incident report submitted to the State Agency documented that R172 fell out of the bed while receiving care from an aide. R172 sustained a head injury and was sent to the hospital for evaluation. R172's hospital records documented, " ...Left lower leg ... nondisplaced (broken bone that did not move out of alignment) fracture impaction fractures of the (left) proximal tibia (upper part of the shin bone) and fibula (lower leg bone) and a head injury. 3/16/24 - A facility document titled, "Educational Opportunity Notice", and dated, 2017, documented, "[E17] will be conscious of resident positioning when providing care to minimize risk of fall or injury. Verbal education provided and	F 689	needs and fall risk prevention strategies are addressed on all residents□ care plans including level of assist required for bed mobility/transfer. Nursing personnel will be educated regarding the proper positioning and turning technique when a dependent resident is on an air mattress. Nursing personnel will be educated regarding the need to communicate this information with the direct care staff and care plan accordingly. "An audit of current residents regarding the level of assist required for bed mobility/transfer has been completed by the Unit Manager. System Changes: ¿ The first Root Cause of the concern was failure to use proper positioning and technique in turning a dependent resident on an air mattress. ¿ The second Root Cause of the concern was a failure to identify and document the number of associates required to safely complete bed mobility. ¿ Current residents were reassessed for the number of associates required for bed-mobility/transfers. ¿ Care-plans for current residents' bed-mobility were reviewed and updated to include the number of associates to move the resident during care. Nursing personnel will be re-educated regarding the designated number of associates for bed-mobility to ensure safety needs and fall risk prevention strategies. ¿ The Unit Manager or Designee will	

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F 689	Continued From page 47 discuss (sic) resident handling. [E17] provided demonstration of what she would do differently, and verbalized understanding of education provided." 7/1/24 9:20 AM - A review of R172's Kardex (electronic document for the aides to inform the staff of the residents' care needs) lacked information of how many staff members were needed to assist with turning, repositioning in bed. R172's care plan also lacked evidence of how many staff members were needed for turning and repositioning. 7/1/24 1:15 PM - During an interview, E5 (Unit Manager) stated, "Physical Therapy determines how many staff members are needed for transfers, and turning and repositioning. This information is then communicated to nursing, and the order then obtained from the doctor, the Kardex and the care plan are updated." 7/1/24 2:17 PM - During an interview, E6 (Physical Therapy Director) stated, "The residents are seen on admission and evaluated for bed mobility and transfer status. This information is given to nursing for the resident's records". E6 failed to give the surveyor any documents of R172's evaluation and recommendations for bed mobility upon request. 7/1/24 2:30 PM - During an interview, E14 and E19 (CNAs), stated that they look at the Kardex for information on residents' care including bed mobility and transfers. 7/2/24 10:30 AM - During an interview, E17 (CNA) stated, "I was cleaning up the lower part of the resident's body and the top half started to roll	F 689	provide random monitoring of current residents to confirm that the number of associates indicated on the care plan are present when moving the resident. Success Evaluation: A 100% audit will be completed to ensure that all nursing personnel are educated on the above-mentioned topics. "An initial 100% audit of current residents to evaluate bed mobility dependence and needed interventions will be completed; then, an audit of a random sample of 10% of residents for bed mobility interventions will be completed by the Unit Manager or Designee to confirm bed mobility interventions are in place per the plan of care; Audits will have a goal of 100% compliance; Audits will be completed weekly until 100% compliance is achieved for 3 consecutive evaluations, then every other week until 100% compliance is achieved for 3 consecutive evaluations, and then monthly until 100% compliance is achieved for 3 consecutive evaluations. "The results of the audits will be provided to the QAPI Committee by the Unit Manager monthly for the next 3 months to determine the need for continued monitoring.	

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F 689	Continued From page 48 off the bed. I tried to grab her feet but I was not able to prevent her from falling". The surveyor asked E17 if she knew how many persons were needed for R172's bed mobility, E17 stated, "I usually look at the Kardex or ask other aides about the residents' care including bed mobility and transfer status but this resident did not have any information about her bed mobility or transfers on the Kardex, so I looked to see what the other aides documented and that's what I did." The surveyor then asked E17 if R172 was able to participate in bed mobility, E17 stated, "Sometimes she would reach for something, but she was not able to help with turning or anything." 7/2/24 11:30 AM - During a telephone interview F3 (R172's daughter) stated, "The only thing my mother was able to do was feed herself, and that was only when the spoon was put in her hand. She was not able to move or do anything else." The facility failed to evaluate how many staff members were needed for R172's bed mobility including turning and repositioning, and that the information was documented on the Kardex for staff to care for her safely. Findings were reviewed during the exit conference on 7/2/24 at 2:15 PM with E1 (NHA), E2 (DON) E3 (ADON), E4 (Clinical Specialist), E32 (Corporate PT) and State of DE Ombudsman (via telephone).	F 689		
F 728 SS=D	Facility Hiring and Use of Nurse Aide CFR(s): 483.35(d)(1)-(3) §483.35(d) Requirement for facility hiring and use of nurse aides- §483.35(d)(1) General rule.	F 728		8/9/24

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F 728	Continued From page 49 A facility must not use any individual working in the facility as a nurse aide for more than 4 months, on a full-time basis, unless- (i) That individual is competent to provide nursing and nursing related services; and (ii)(A) That individual has completed a training and competency evaluation program, or a competency evaluation program approved by the State as meeting the requirements of §483.151 through §483.154; or (B) That individual has been deemed or determined competent as provided in §483.150(a) and (b). §483.35(d)(2) Non-permanent employees. A facility must not use on a temporary, per diem, leased, or any basis other than a permanent employee any individual who does not meet the requirements in paragraphs (d)(1)(i) and (ii) of this section. §483.35(d)(3) Minimum Competency A facility must not use any individual who has worked less than 4 months as a nurse aide in that facility unless the individual- (i) Is a full-time employee in a State-approved training and competency evaluation program; (ii) Has demonstrated competence through satisfactory participation in a State-approved nurse aide training and competency evaluation program or competency evaluation program; or (iii) Has been deemed or determined competent as provided in §483.150(a) and (b). This REQUIREMENT is not met as evidenced by: Based on a review of documents and interviews, the facility failed to ensure that nursing staff demonstrated competence through satisfactory participation in a State approved nurse aide	F 728	Corrective Action: "E3 is an employee of an employment agency.	

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F 728	Continued From page 50 training and competency evaluation program. Findings include: 7/1/24 - A review of facility documentation revealed that E15 (CNA Agency) had worked at the facility on the following dates: 9/23/23 9/24/23 10/28/23 12/19/23. 7/1/24 4:10 PM - During an interview, E3 (ADON) and E41(Consulting DON) stated that they were unable to produce a valid CNA certification from E15's employment agency. 7/2/24 12:07 PM - Validation was received from DHSS/DHCQ that E15's did not hold a Delaware CNA certificate and is not on the State of DE CNA Registry. Findings were reviewed during the exit conference on 7/2/24 at 2:15 PM with E1 (NHA), E2 (DON), E3 (ADON), E4 (Clinical Specialist), and State of DE Ombudsmen (via telephone).	F 728	"E3 was banned from being scheduled at Shipley Living until Delaware C.N.A certificate is provided to the Shipley Administrator. Identification of Other Residents: "Current associates have the potential to be affected. "In order to prevent residents from being affected, the HR Director has completed a 100% audit of all current nurse aides to confirm current staff have completed a state approved nurse aide training program and are properly certified in the State of Delaware. System Changes: "The Root Cause of the concern was a failure to follow the requirements for ensuring that all nurse aides have received state approved certification for the intended position prior to reporting to scheduled shift. "The facility system for managing the hiring of nurse aides has been updated to include a nurse aide training verification review by the Administrator or Human Resource Director upon hire, and monthly "Agency personnel will be verified to have a valid C.N.A certificate in DE by the Human Resource Director or designee prior to reporting for their initial scheduled shift. Success Evaluation: "A nurse aide certification audit of a	

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F 728	Continued From page 51	F 728	random sample of 10% of nurse aides to ensure compliance with nurse aide training requirements will be completed by the Administrator or designee; Audits will have a goal of 100% compliance; Audits will be completed weekly until 100% compliance is achieved for 3 consecutive evaluations, then every other week until 100% compliance is achieved for 3 consecutive evaluations, and then monthly until 100% compliance is achieved for 3 consecutive evaluations. "The results of the audits will be provided to the QAPI Committee by the HR Director monthly for the next 3 months to determine the need for continued monitoring.	
F 730 SS=D	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on a review of facility documents and interview, it was determined that the facility failed to complete a performance review every twelve months for one (E16) out of five nurse aides. Findings include: The facility was provided a list of five names of CNAs to provide documentation of the completion of annual performance evaluations.	F 730	Corrective Action: "A performance evaluation was completed for E16. "Corrective actions have been ensured by the Administrator and the Director of Nursing. The required annual performance review will be completed for currently employed nurse aides by the	8/9/24

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F 730	Continued From page 52 7/1/24 - A review of E16's performance evaluation documentation revealed the lack of an 2024 annual performance evaluation since E16 was hired on 2/22/23. 7/1/24 12:30 PM - During an interview, E21 (HR) confirmed that E16 has not had an annual performance evaluation since E16 was hired on 2/22/23. Findings were reviewed during the exit conference on 7/2/24 at 2:15 PM with E1 (NHA), E2 (DON), E3 (ADON), E4 (Clinical Specialist), and State of DE Ombudsmen (via telephone).	F 730	date of compliance or prior to the next scheduled shift. Identification of Other Residents: "Current associates have the potential to be affected. "In order to prevent residents from being affected, the Human Resources Associate or Administrator reviewed the current associate's annual nurse aide performance evaluations to confirm compliance with Annual Evaluations. System Changes: "The Root Cause of the concern was a failure to adhere to the requirement to complete an annual performance review for current nurse aides. "The facility system for managing the nurse aide Annual Performance Review has been updated to include a calendar with a plan for 100% completion by quarter four of the year and review of compliance in the monthly Quality Assurance and Performance Improvement (QAPI) committee meeting in January of the following year. "The administrator or designee will provide oversight to ensure ongoing compliance. Success Evaluation: "A nurse aide evaluation audit to confirm compliance of annual evaluation requirements will be completed by the Administrator or designee; Audits will	

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F 730	Continued From page 53	F 730	have a goal of 100% compliance; Audits will be completed weekly until 100% compliance is achieved for 3 consecutive evaluations, then every other week until 100% compliance is achieved for 3 consecutive evaluations, and then monthly until 100% compliance is achieved for 3 consecutive evaluations. "The results of the audits will be provided to the QAPI Committee by the DON/HR Director monthly for the next 3 months to determine the need for continued monitoring.	
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.	F 755		8/9/24

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F 755	Continued From page 54 §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, it was determined that for one (R54) out of six reviewed for Pharmacy Services, the facility failed to ensure that the pharmacy services provided safe and effective medication use. Findings include: Facility Medication Regimen Review (MRR) Policy Statement- "the consultant pharmacist reviews the medication regimen of each resident monthly ...5. The MRR involves a thorough review of the resident's medication record to prevent ... d. inadequate monitoring for adverse consequences ...g. incorrect medications, administration times or dosage forms ...". May 2019 Combination Use of Clopidogrel and Proton Pump Inhibitors Increase Major Adverse Cardiovascular Events (MACE) in patients with Coronary Artery Disease: A meta-Analysis- "In conclusion, the result of out meta-analysis supports the notion that the combination use of clopidogrel and PPIs (such as protonix) will increase the risk of MACE in patients with coronary artery disease, which is in accordance with pharmacokinetic and pharmacodynamic studies." Journal of Cardiovascular Pharmacology and Therapeutics 2017, Vol 22(2), 142-152.	F 755	Corrective Action: There is no opportunity to correct the previous error regarding pharmacy services for Resident R54. In order to prevent a recurrence, all nursing personnel will be educated on the requirements regarding safe and effective pharmacy services. Identification of Other Residents: "Current Residents prescribed protonix and clopidogrel have the potential to be affected. System Changes: "The Root Cause of the concern was a failure to separate the administration time of the following medications: protonix and clopidrogel. "Current resident(s) prescribed protonix or clopidrogel were identified and a medication review was completed to confirm that there were no medication interactions and issues with the timing of administration.	

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F 755	Continued From page 55 5/16/23 - R54 was admitted to the facility with diagnoses, including but not limited to, multiple sclerosis and stroke affecting R54's right side. 5/22/24 - E36 (DO) ordered, "Clopidogrel bisulfate tablet 75 mg via G-tube one time a day for prevent blood clot." 5/22/24 _ E36 (DO) ordered, "Protonix tablet delayed release 40 mg- give 40 mg via G-tube one time a day for GERD (Gastroesophageal reflux disease)." The facility failed to ensure that the pharmacist assured the correct formulation of the medication protonix was utilized. A delayed released tablet should not be administered via a G-tube. 5/28/24 - E39 (Consultant Pharmacist) completed a Medication Regimen Review (MRR) and found no irregularities. 6/18/24 - E39 (Consultant Pharmacist) completed a Medication Regimen Review (MRR) and found no irregularities. 6/25/24 - Review of R54's Medication Administration Record (MAR) for June 2024 revealed protonix 40mg was scheduled to be given at 7:30 AM and clopidogrel 75 mg was scheduled to be given at 8AM. The facility failed to ensure that the pharmacist defined a schedule for administering medications (protonix and clopidogrel) that prevented potential significant medication interactions. 6/25/24 - Review of R54's June 2024 order set	F 755	"The facility system for review of Pharmacy Services for potential medication interaction has been updated to include a monthly review meeting between the Director of Nursing and the Consultant Pharmacist to review current practices and address any potential medication interaction with prescribed. "The Director of Nursing or Designee will complete education to current nursing staff regarding the process to identify medication interaction and notification to the prescribing physician. Success Evaluation: "An initial 100% audit of Medication Regimen Review has been completed by the Pharmacy Consultant. All recommendations for the last 3 months were reviewed to ensure accuracy of all recommendations. "Subsequent Audits of a random sample of 10% of the Medication Regimen Review pharmacy recommendations for the previous month will be completed by the Director of Nursing or Designee to confirm compliance on recommendations; "Audits will have a goal of 100% compliance; Audits will be completed weekly until 100% compliance is achieved for 3 consecutive evaluations, then every other week until 100% compliance is achieved for 3 consecutive evaluations, and then monthly until 100% compliance is achieved for 3 consecutive evaluations. "The results of the audits will be provided to the QAPI Committee by the Consultant Pharmacist monthly for the next 3 months	

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F 755	Continued From page 56 revealed a pharmacy warning notation next to the protonix and clopidogrel orders that stated, "Coadministration of pantoprazole and clopidogrel may increase the risk of major adverse cardiovascular events." 6/26/24 8:05 AM - E26 (LPN) administered protonix and clopidogrel to R54 via her G-tube. 7/2/24 11:00 AM - E4 (Clinical specialist) confirmed that the scheduled timings of the protonix and clopidogrel needed to be changed to allow more time between these medications administrations. E4 also stated, "[R54] should be on a different formulation of protonix (rather than a delayed release tablet) since the medication was being crushed and administered via a G-tube." Findings were reviewed during the exit conference on 7/2/24 at 2:15 PM with E1 (NHA), E2 (DON), E3 (ADON), E4 (Clinical Specialist) and two State of DE Ombudsmen (via telephone).	F 755	to determine the need for continued monitoring	
F 838 SS=C	Facility Assessment CFR(s): 483.70(e)(1)-(3) §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must	F 838		8/9/24

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F 838	Continued From page 57 address or include: §483.70(e)(1) The facility's resident population, including, but not limited to, (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population; (iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population; (iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.70(e)(2) The facility's resources, including but not limited to, (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies; (iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and	F 838		

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F 838	Continued From page 58 (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: F838 Facility Assessment- Based on record review and interview, it was determined that the facility failed accurately update the Facility Assessment Tool, which was created May 2024, with the correct name of the Infection Preventionist. Findings include: 6/26/24 11:45 AM - Review of the Facility Assessment, which was dated May 2024, revealed on page 5 Infection Preventionist: [E3] (ADON). 6/27/24 1:56 PM - During an interview, E4 (Clinical Specialist) stated, "That's not right. [E2] (DON) is the facility Infection Preventionist. [E3] cannot be the Infection preventionist; she is not certified." 7/1/24 10:46 AM - During an interview, E4(Clinical specialist) stated, "Infection control is a group effort while we try to fill the role. We had someone and then at the last minute, they turned down the role. [E2] (DON), [E3] (ADON) and [E33] (RN/MDS Coordinator) work on it together. The facility provided proof of E33's training and certification for the role of Infection Preventionist. Findings were reviewed during the exit	F 838	Corrective Action: "Corrective actions have been ensured by the Administrator and Director of Nursing. The Administrator updated the Facility Assessment to reflect the current resources necessary to care for the resident population. Identification of Other Residents: "Current Residents have the potential to be affected. "The Administrator updated the Facility Assessment to reflect the current resources necessary to care for the resident population on July 1, 2024. System Changes: "The Root Cause of the concern was a failure to adhere to the facility policy for Facility Assessment (rev. 10.2018). The facility policy for Facility Assessment (rev. 10.2018) was reviewed and found to meet professional standards. "The facility assessment will be maintained annually and as needed. "The facility system for maintaining the	

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F 838	Continued From page 59 conference on 7/2/24 at 2:15 PM with E1 (NHA), E2 (DON), E3 (ADON), E4 (Clinical Specialist) and two State of DE Ombudsmen (via telephone).	F 838	Facility Assessment has been updated to include a quarterly review in the Quality Assurance and Performance Improvement (QAPI) committee meeting and an annual revision, at minimum. "The Administrator will provide oversight to ensure ongoing compliance. Success Evaluation: "An initial audit review of the contents of the Facility Assessment has been completed. Subsequent Audits will verify the continued accuracy of the contents of the Facility Assessment; "Audits will have a goal of 100% compliance; Audits will be completed weekly until 100% compliance is achieved for 3 consecutive evaluations, then every other week until 100% compliance is achieved for 3 consecutive evaluations, and then monthly until 100% compliance is achieved for 3 consecutive evaluations. "The results of the audits will be provided to the QAPI Committee by the Administrator monthly for the next 3 months to determine the need for continued monitoring.	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information	F 842		8/9/24

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F 842	Continued From page 60 except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for-	F 842		

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F 842	Continued From page 61 (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, it was determined that for one (R22) out of four residents reviewed for Advanced Directives, the facility failed maintain accurately documented medical records regarding R22's code status. Findings include: 4/27/21 - R22 was admitted to the facility with diagnoses, including but not limited to, atrial fibrillation, heart failure and dementia. 12/16/22 - E36 (DO) completed a Delaware Medical Orders for Scope of Treatment (DMOST) with F2 (R22's son/POA), which stated that R22 was to have CPR/ attempt resuscitation. 11/28/23 - E36 (DO) ordered, "CPR- FULL code status" in R22 's EMR.	F 842	Corrective Action: "Resident R22 was provided the opportunity to review and complete an Advanced Directive that reflects the resident□s treatment decisions on July 1, 2024 by the Director of Social Services. "The care plan was reviewed for Resident R22 and accurately reflects the resident□s desired Advanced Directive decisions. Identification of Other Residents: "Current residents have the potential to be affected. "In order to prevent other residents from being affected, current nursing and social services staff members will be reeducated	

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F 842	Continued From page 62 2/27/24 - E36 (DO) documented in R22's EMR a progress note that stated," ...History-Code Status List: Full scope of treatment ...Advanced Care Planning details: Pt and family agreed to discuss advance directive. Patient and family would like to remain DO NOT RESUSCITATE (DNR) with no artificial nutrition or hydration through conduit." Within the same note, there is documentation of both a full code status and a DNR status for R22. 4/3/24 - E36 (DO) documented in R22's EMR a progress note that stated," ...History-Code Status List: Full code ...Advanced Care Planning details: Pt and family agreed to discuss advance directive. Patient and family would like to remain DO NOT RESUSCITATE (DNR) with no artificial nutrition or hydration through conduit." Within the same note, there is documentation of both a full code status and a DNR status for R22. 5/1/24 - R22's annual MDS documented a Basic Inventory of Mental Status (BIMS) score of 15, which reflected normal cognition. 6/25/24 3:45 PM - During an interview, R22 stated that he wanted CPR and "everything done". 7/2/24 11:11 AM - During an interview, when shown the conflicting documentation in E36's 2/27/24 and 4/3/24 progress notes, E4 (Clinical specialist) stated, "Yeah, we need to get that straightened out. [E36]'s note states that R22 is a full code but then later in the notes it is documented that the patient and the family would like to remain a DNR. That is confusing. But the	F 842	on resident rights, including the right to make treatment decisions and to have the opportunity to complete an Advanced Directive. "A 100% audit of all resident advanced directives will be completed by the Director of Social Services or Designee to confirm each resident advance care treatment decisions indicated. System Changes: "The Root Cause of the concern was the failure to accurately adhere to the required elements in the policy Advanced Directives (revised 12.2016). The facility policy Advanced Directives (revised 12.2016) was reviewed and found to meet professional standards. "The Director of Social Services or Designee will complete education for current nursing and social services staff on the requirements for Residents Rights, including the right to make treatment decisions and to have the opportunity to complete an Advanced Directive. "The Director of Social Services associate will provide oversight to ensure ongoing compliance. Success Evaluation: "An audit of a random sample of 10% of resident advanced directives will be completed by the Social Service associate or Designee to confirm compliance with Residents Rights, including the right to make treatment decisions and to have the opportunity to complete an Advanced	

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F 842	Continued From page 63 order in the EMR and the DMOST match. Both state that R22 is a full code." Findings were reviewed during the exit conference on 7/2/24 at 2:15 PM with E1 (NHA), E2 (DON), E3 (ADON), E4 (Clinical Specialist) and two State of DE Ombudsmen (via telephone).	F 842	Directive; the audits will confirm the presence of an Advanced Directive, the physician order that reflects the treatment choices, and the care plan for the advanced directive; "Audits will have a goal of 100% compliance; Audits will be completed weekly until 100% compliance is achieved for 3 consecutive evaluations, then every other week until 100% compliance is achieved for 3 consecutive evaluations, and then monthly until 100% compliance is achieved for 3 consecutive evaluations. "The results of the audits will be provided to the QAPI Committee by the Director of Social Services monthly for the next 3 months to determine the need for continued monitoring.	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents,	F 880		8/9/24

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F 880	Continued From page 64 staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed 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.	F 880		

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F 880	Continued From page 65 §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 reviews and interviews, it was determined that for seven (R13, R22, R33, R34, R47, R54, R270) out of seventeen residents reviewed for Infection Control, it was determined that the facility failed to establish and maintain an infection prevention and control program that included Enhanced Barrier Precautions (EBP). Additionally, it was determined that for 3 (three) R34, R47, R270 residents reviewed for urinary catheter care the facility failed to ensure a safe and sanitary process regarding urinary collection bags. Findings include: Facility Enhanced Barrier Precautions (EBP) Policy Statement- "Enhanced barrier precautions (EBPs) are utilized to prevent the spread of multi-drug resistant organisms (MDROs) to residents ...Policy Interpretation and Implemenetation..2. EBPs employ targeted gown and glove use during high-contact resident care activities when contact precautions do not otherwise apply. a. Gloves and gowns are applied before performing the high-contact resident care activity (as opposed to before entering the room) ...3. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include: ...d. providing hygiene; e. changing linens; f. changing briefs or assisting with toileting; g. device care or use (central line,	F 880	Corrective Action: "R13, R 22, R33, R34, R47, R54, R270 were placed in Enhanced Barrier Precautions. Identification of Other Residents: "Current residents with an MDRO have the potential to be affected. "In order to prevent other residents from being affected, the facility has system for daily nursing management rounds has been updated to include a focus on ensuring infection control compliance, including maintaining catheter drainage bags off of the floor and in a dignity bag. "Enhanced Barrier Precautions has been initiated for all identified residents. System Changes: "The Root Cause of the concern was a failure to adhere to the facility policy for Infection Prevention and Control Program (rev. 10.2018). The facility policy for Infection Prevention and Control Program (rev. 10.2018) was reviewed and found to meet professional standards.	

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F 880	Continued From page 66 urinary catheter, feeding tube ...); ...10. Signs are posted in the door or wall outside the resident room indicating the type of precautions and PPE required...". May 4, 2024 1.Review of R13's clinical record revealed: 5/24/24 - R13 was admitted to the facility into room 615b. 6/19/24 - R13's hospital records documented "prior MDROs infections" and a diagnosis of extended spectrum beta-lactamase (ESBL) urinary tract infection (UTI). R13's medical history indicated that EBPs would be required. There was no evidence of EBP signage or personal protective equipment (PPE) outside R13's room. 2. Review of R22's clinical record revealed: 4/27/21 - R22 was admitted to the facility into room 707a. 6/26/24 9:10 AM- Observation of the wound team rounding and providing care to R22's left heel resolving wound without any gown. Gloves were worn. R22's medical diagnosis list in his electronic medical record (EMR) documented ICD 10 code Z16.12 Extended spectrum beta lactamase (ESBL) resistance of his left heel wound. R22's medical record also documented a history of methicillin-resistant Staphylococcus aureus (MRSA) infection.	F 880	"The nursing management team has been reeducated regarding the requirements of infection control, including maintaining catheter drainage bags off of the floor, in a dignity bag and implementing Enhanced Barrier Precautions by the Clinical Specialist. "The direct care associates were educated on the Enhanced Barrier Precaution system by Director of Nurses or designee. The facility system for managing the Infection Prevention and Control Program has been updated to include a monthly review of compliance with Infection Control standards in the monthly Quality Assurance and Performance Improvement (QAPI) committee meeting. "The nursing management team will provide oversight to ensure ongoing compliance. Success Evaluation: "An Infection Control compliance audit to ensure proper Infection Control compliance, including catheter bags remain off of the floor and Enhanced Barrier Precautions are implemented, will be completed by the Director of Nursing or designee on a random sample of 10% of residents; "Audits will have a goal of 100% compliance; Audits will be completed daily until 100% compliance is achieved for 3 consecutive evaluations, then 3 times a week until 100% compliance is achieved for 3 consecutive evaluations, then weekly until 100% compliance is achieved for 3	

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F 880	Continued From page 67 Both of these infections qualified as MDROs and therefore, R22 required EBP. 3. Review of R33's clinical record revealed: 11/30/23 - R33 was admitted to the facility into room 508b. 12/28/23 - R33's medical record documented a urine culture with Escherichia (E) coli ESBL infection. 4/28/24 - R33's medical record documented a second urine culture with E.coli ESBL. Review of R33's hospital records revealed a MRSA positive culture while hospitalized in November 2023. Both of these infections (E.coli ESBL UTI and MRSA) qualified as MDROs and therefore, R33 required EBP. There was no evidence of EBP signage or personal protective equipment (PPE) outside R33's room. 4. Review of R34's clinical record revealed: 5/4/23 - R34 was admitted to the facility into room 514b. 5/10/24 - R34's medical record documented a urine culture with Klebsiella pneumoniae ESBL. 5/10/24 - E36 (DO) ordered in R34's EMR, "Document indwelling foley catheter output Q (every) shift related to urinary retention."	F 880	consecutive evaluations, and then monthly until 100% compliance is achieved for 3 consecutive evaluations. "The results of the audits will be provided to the QAPI Committee by the DON/ADON or Designee monthly for the next 3 months to determine the need for continued monitoring.	

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F 880	Continued From page 68 Both the infection (Klebsiella pneumoniae ESBL UTI), which was a MDRO, and the indwelling foley catheter (medical device) were indications for EBP; therefore, R34 required EBP. There was no evidence of EBP signage or personal protective equipment (PPE) outside R34's room. 5. Review of R47's clinical record revealed: 2/12/23 - R47 was admitted to the facility into room 602a. 3/7/24 - E36 (DO) ordered in R47's EMR, "Check foley catheter Q shift for clogging." 5/29/24 - R47's medical record documented a urine culture with Vancomycin resistant enterococcus faecalis (VRE) and MRSA. Both of the infections (VRE and MRSA UTIs), which was a MDRO, and the indwelling foley catheter (medical device) were indications for EBP; therefore, R47 required EBP. There was no evidence of EBP signage or personal protective equipment (PPE) outside R47's room. 6. Review of R54's clinical record revealed: 5/16/23 - R54 was admitted to the facility into room 712b. 5/16/23 - E36 (DO) ordered in E54's EMR, "Check placement of tube (G-tube) and residual every shift ...".	F 880		

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F 880	Continued From page 69 6/27/24 8:05 AM - Observation of E26 (LPN) administering R54's medications via her G-tube without utilizing EBP. E26 did have gloves on. The presence of the G-tube (feeding tube) was an indication for R54 to be on EBP. There was no evidence of EBP signage or personal protective equipment (PPE) outside R54's room. 7. Review of R270's clinical record revealed: 6/19/24 - R270 was admitted to the facility into room 512b from another facility. R270's transfer paperwork listed a diagnosis of history of ESBL infection. 6/16/24 - E36 (DO) ordered in R270's EMR, "Empty foley catheter bag every shift." The presence of the indwelling foley catheter (medical device) and history of ESBL infection were both indications for R270 to be on EBP. 6/27/24 2:37 PM - During an interview, E43 stated that she does not wear any protective clothing or coverings other than gloves when emptying the foley catheter bag for R 270. 6/27/24 2:56 PM - During an interview, E26 (LPN) stated, "We do use yellow gowns at times. If the resident is on precautions, the facility puts a sign up. I don't get a lot of residents on precautions because this is the long-term care wing of the facility." 7/1/24 10:52 AM - Observation of rooms 508b,	F 880		

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F 880	Continued From page 70 512b, 514b, 615b, 707a, and 712b revealed no signage stating the residents in those rooms were on EBPs. 7/2/24 10:35 AM - A poll of all five surveyors revealed that at no point during the previous six days of the survey had any surveyor observed any staff providing direct patient care to any residents while utilizing EBP (wearing a yellow gown and gloves). 7/2/24 11:04 AM - During an interview, E4 (Clinical Specialist) stated, "We are doing EBP. We list it on [the EMR] next to the resident's name." E4 pulled up a resident on the EMR to show the surveyor the EBP order. E4 stated, "Oh my God, it's not there and there is no order (pointing to the EMR). We are doing it our other two facilities." 8. Review of R34's clinical records revealed: 5/4/24 - R34 was admitted to the facility with diagnoses including adult failure to thrive, seizure, and neurogenic bladder. 5/10/24 - R34's clinical records included, "Ensure that tubing and dignity bag are off the floor." 5/13/24 - R34's care plan included, "Privacy bag at all times." 6/24/24 10:30 AM - R34 was observed lying in the bed, an uncovered, undated urinary collection bag with yellow urine was observed on the floor on the left side of the bed. An undated/unlabeled urinary collection container was observed on the toilet seat of the shared bathroom.	F 880		

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F 880	Continued From page 71 6/24/24 1:30 PM - R34 was observed lying in the bed, the uncovered, undated urinary collection bag with yellow urine continued to be on the floor on the left side of the bed. An undated/unlabeled urinary collection container was observed on the toilet seat of the shared bathroom. 6/25/24 - 10:30 AM R34 was observed lying in the bed, an uncovered, undated urinary collection bag with yellow urine was observed on the right side of the bed on the floor. An undated/unlabeled urinary collection container was observed on the toilet seat of the shared bathroom. 6/25/24 - 2:30 PM: R34 was observed lying in the bed, an uncovered, the undated urinary bag with yellow urine continued to be observed on the right side of the bed on the floor. An undated/unlabeled urinary collection container was observed on the toilet seat of the shared bathroom. 6/25/24 3:00 PM - Findings were confirmed with E3 (ADON) and E4 (Clinical Specialist) stated. 9. Review of R47's clinical records revealed: 1/6/22 - R47 was admitted to the facility with diagnoses including urinary tract infections, neurogenic bladder, hypertension, and seizure disorder. 5/10/23 - R47's clinical records documented, "Check tubing for kinks, and privacy bag at all times, secure catheter to reduce friction." 6/24/24 10:30 AM - R47 was observed lying in	F 880		

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F 880	Continued From page 72 bed, an undated, uncovered urinary collection bag with yellow urine was observed touching the floor on the left side of the bed. An undated/unlabeled urinary collection container was observed on the grab bar of the bathroom. 6/24/24 2:30 PM - R 47 was observed lying in bed, the undated, uncovered urinary collection bag with yellow urine continued to be touching the floor on the left side of the bed. An undated/unlabeled urinary collection container was observed on the grab bar of the bathroom 6/25/25 10:00 AM - R47 was observed lying in bed, an uncovered, undated urinary collection bag with yellow urine hanging on the right side of the bed and visible from the doorway. An undated/unlabeled urinary collection container was observed on the grab bar of the bathroom 6/25/24 2:30 PM - R47 was observed lying in bed, an uncovered, undated urinary collection bag with yellow urine in a wash basin was on the left side of the bed on the floor.An undated/unlabeled urinary collection container was observed on the grab bar of the bathroom 6/25/24 3:00 PM - Findings were confirmed with E3 (ADON) and E4 (Clinical Specialist). 10. Review of R270's clinical records revealed: 6/19/24 - R270 was admitted to the facility with multiple diagnoses, including obstructive uropathy, and R270 had a foley utinary catheter in place at admission. The following observations were made on 6/25/24 of R270's foley urinary catheter drainage bag:	F 880		

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F 880	Continued From page 73 10:30 AM - The foley urinary catheter drainage bag was on the facility floor. 11:30 AM - The foley urinary catheter drainage bag was on the facility floor. 11:41 AM - R270 was observed to be wheeled by a CNA the facility shower room with an uncovered foley urinary catheter bag dragging on the floor. 6/25/24 11:41AM - Findings were confirmed with E3 (ADON) and E4 (Clinical Specialist). Findings were reviewed during the exit conference on 7/2/24 at 2:15 PM with E1 (NHA), E2 (DON) E3 (ADON), E4 (Clinical Specialist) and State of DE Ombudsman (via telephone).	F 880		
F 882 SS=D	Infection Preventionist Qualifications/Role CFR(s): 483.80(b)(1)-(4) §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP) (s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized	F 882		8/9/24

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F 882	Continued From page 74 training in infection prevention and control. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, it was determined that the facility failed to have a designated infection preventionist with specialized training in infection prevention and control. Findings include: May 2024 - Review of the Facility Assessment, which was dated May 2024, revealed on page 5, the Infection Preventionist was the ADON (E3). 6/27/24 1:28 PM - During an interview, E33 (RN/MDS Coordinator) stated, "I am not the Infection Preventionist. It is [E3] (ADON)." 6/27/24 1:56 PM - During an interview, E4 (Clinical Specialist) stated, "That's not right. [E2] (DON) is the facility Infection Preventionist. [E3] cannot be the Infection preventionist; she is not certified." 7/1/24 10:46 AM - During an interview, E4 (Clinical Specialist) stated, "Infection control is a group effort while we try to fill the role. We had someone and then at the last minute, they turned down the role. [E2] (DON), [E3] (ADON) and [E33] (RN/MDS Coordinator) work on it together." 7/1/24 12:26 PM - The facility has not been able to provide a copy of E2's Infection preventionist training certificate as it was sent to her previous place of employment's email and she is unable to retrieve it. The facility did not provide a copy of E33's Infection Preventionist training certificate. 7/2/24 11:09 AM - During an interview, E4 (Clinical Specialist) stated, "[E2] (DON) is still	F 882	Corrective Action: Corrective actions have been ensured by the Director of Nursing. The facility has hired a qualified Infection Preventionist who oversees the Infection Prevention and Control Program and completes infection surveillance and monitors all antibiotic utilization to ensure antibiotic stewardship. Identification of Other Residents: "Current Residents have the potential to be affected. "All Residents have the potential to be affected. In order to prevent other residents from being affected, the facility has hired a qualified Infection Preventionist. The facility will also complete a 100% audit of all current resident antibiotic orders to ensure proper infection surveillance and antibiotic utilization and stewardship. System Changes: "The Root Cause of the concern was a failure to adhere to the facility policy for Infection Prevention and Control Program (rev. 10.2018) and the facility policy for Infection Preventionist (rev. 7.2016). The facility policy for Infection Prevention and Control Program (rev. 10.2018) and the facility policy for Infection Preventionist (rev. 7.2016) were reviewed and found to	

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F 882	Continued From page 75 trying to get a copy of her certification from [previous place of employment]. But we changed the name of the Infection preventionist on the Facility Assessment to [E33] (RN/MDS Coordinator), who is certified." 7/2/24 11:49 AM- The facility provided a copy of the Facility Assessment Tool page 5 which now stated E33 (RN/MDS Coordinator) was the facility Infection Preventionist. Findings were reviewed during the exit conference on 7/2/24 at 2:15 PM with E1 (NHA), E2 (DON), E3 (ADON), E4 (Clinical Specialist) and two State of DE Ombudsmen (via telephone).	F 882	meet professional standards. "The facility system for managing the Infection Prevention and Control Program has been updated to include a monthly review of compliance with the Infection Preventionist monitoring including identification of Enhanced Barrier Precautions for review at the monthly Quality Assurance and Performance Improvement (QAPI) committee meeting. The nursing management team will provide oversight to ensure ongoing compliance. Success Evaluation: "An initial 100% audit of current resident infections and antibiotic orders to ensure proper Infection Preventionist monitoring of infection surveillance was implemented. "Subsequent Audits of the Infection Prevention and Control Program and the monitoring of antibiotic utilization to ensure compliance with infection control program and antibiotic stewardship requirements will be completed by the Director of Nursing or designee; Audits will have a goal of 100% compliance; Audits will be completed weekly until 100% compliance is achieved for 3 consecutive evaluations, then every other week until 100% compliance is achieved for 3 consecutive evaluations, and then monthly until 100% compliance is achieved for 3 consecutive evaluations. "The results of the audits will be provided to the QAPI Committee by the ADON monthly for the next 3 months to determine the need for continued	

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F 882	Continued From page 76	F 882	monitoring.	
F 883 SS=E	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 immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the	F 883		8/9/24

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F 883	Continued From page 77 immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for nine (R4, R13, R18, R19, R33, R45, R51, R60 and R223) out of seventeen residents reviewed for vaccines, the facility failed to document in each resident's medical record the administration of the pneumococcal and/or influenza vaccines. Additionally, it was determined that for one (R22) out of seventeen residents reviewed for immunizations, the facility failed to offer R22 an updated pneumococcal vaccine. Findings include: Vaccinations of Residents Policy Statement- "All residents will be offered vaccines that aid in preventing infectious diseases unless the vaccine is medically contraindicated or the resident has already been vaccinated ...All new residents shall be assessed for current vaccination status upon admission ...If the resident receives a vaccine, at	F 883	Corrective Action: "Immunization documentation for residents R4, R13, R18, R19, R33, R45, R51, R60, and R223 has been updated in the EHR. Identification of Other Residents: "Current Residents have the potential to be affected by the alleged deficient practice. "A 100% audit was completed for current residents to confirm residents had been offered the Influenza and Pneumococcal vaccinations as applicable. "Residents who request and consent to the Influenza and/or Pneumococcal vaccinations have received the	

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F 883	Continued From page 78 least the following information shall be documented in the resident's medical record: a. site of administration; b. date of administration; c. lot number of the vaccine (located on the vial); d. expiration date (located on the vial); and e. name of person administering the vaccine ..." October 2019 Pneumococcal Vaccine Policy Statement- "All residents will be offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections ...2. Assessments of pneumococcal vaccination status will be conducted within five (5) working days of the resident's admission ...6. For residents who receive the vaccines, the date of vaccination, lot number, expiration date, person administering, and the site of vaccination will be documented in the resident's medical record ..." October 2019 Influenza Vaccine Policy Statement- "All residents and employees who have no medical contraindications to the vaccine will be offered the influenza vaccine annually to encourage and promote the benefits associated with vaccinations against influenza ... 1. Between October 1st and March 31st each year, the influenza vaccine shall be offered to residents ...5. For those who receive the vaccine, the date of vaccination, lot number, expiration date, person administering, and the site of vaccination will be documented in the resident's medical record ...6. A resident's refusal of the vaccine shall be documented on the informed consent for influenza vaccine and placed in the resident's medical record ...10 Residents ...may obtain their influenza vaccines from their personal physicians. Documentation of previous vaccination should be provided to the facility ..." October 2019	F 883	appropriate vaccine, and documentation maintained in the immunization record. System Changes: "The facility policy for Influenza Vaccine (Rev. 3.2022) and Pneumococcal Vaccine (Rev. 3.2022) were reviewed and found to meet professional standards. Staff education has been provided to all staff to ensure that resident Influenza Pneumococcal Vaccination requirements are understood and completed. "The facility system for Influenza and Pneumococcal Vaccine requirements has been updated to include a monthly IDT Review of current residents' vaccination consents and administration to confirm residents who have requested and consented to the Influenza and/or Pneumococcal vaccinations have received the appropriate vaccine and that this has been documented in the immunization record. "The nursing management team will provide oversight to ensure ongoing compliance. Success Evaluation: "An initial 100% audit will be completed for current residents to ensure that all residents have been offered the Influenza and Pneumococcal vaccinations as applicable, and that those who have requested and consented to the Influenza and/or Pneumococcal vaccinations have received the appropriate vaccine. Subsequent Audits of a random sample of	

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F 883	Continued From page 79 1. Review of R4's clinical record revealed: 1/21/24 - R4 was admitted to the facility. 2/20/24 - R4 received the PCV20 (pneumococcal 20-valent conjugant) vaccine, which was documented in the DELVAX website. 6/27/24 8:00 PM - Review of R4's electronic medical record (EMR) revealed the PCV20 pneumococcal vaccine that was administered on 2/20/24 was not documented. There also was no documentation of the influenza vaccine that R4 received at the hospital on 1/14/24, which was documented in DELVAX. 2. Review of R13's clinical record revealed: 5/24/24 - R13 was admitted to the facility. 2/20/24 - R13 received the PCV20 vaccine, which was documented in the DELVAX website. 6/27/24 8:00 PM - Review of R13's EMR revealed the PCV20 pneumococcal vaccine that was administered on 2/20/24 was not documented. There also was no documentation of a 2023/24 influenza vaccine or the declination of that vaccine provided by the facility. 3. Review of R18's clinical record revealed: 6/1/22 - R18 was admitted to the facility. 2/20/24 - R18 received the PCV20 vaccine, which was documented in the DELVAX website. 6/27/24 8:00 PM - Review of R18's EMR revealed	F 883	10% of current residents will be completed by the Director of Nursing or Designee to confirm resident vaccinations as required; Audits will have a goal of 100% compliance; Audits will be completed weekly until 100% compliance is achieved for 3 consecutive evaluations, then every other week until 100% compliance is achieved for 3 consecutive evaluations, and then monthly until 100% compliance is achieved for 3 consecutive evaluations. "The results of the audits will be provided to the QAPI Committee by the ADON monthly for the next 3 months to determine the need for continued monitoring.	

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F 883	Continued From page 80 the PCV20 pneumococcal vaccine that was administered on 2/20/24 was not documented. 4. Review of R19's clinical record revealed: 4/2/16 - R19 was admitted to the facility. 2/20/24 - R19 received the PCV20 vaccine, which was documented in the DELVAX website. 6/27/24 8:00 PM - Review of R19's EMR revealed the PCV20 pneumococcal vaccine that was administered on 2/20/24 was not documented. There also was no documentation of a 2023/24 influenza vaccine or the declination of that vaccine provided by the facility. 5. Review of R33's clinical record revealed: 11/30/23 - R33 was admitted to the facility. 2/20/24 - R33 received the PCV20 vaccine, which was documented in the DELVAX website. 6/27/24 8:00 PM - Review of R33's EMR revealed the PCV20 pneumococcal vaccine that was administered on 2/20/24 was not documented. 6. Review of R45's clinical record revealed: 6/23/23- R45 was admitted to the facility. 2/20/24 - R45 received the PCV20 vaccine, which was documented in the DELVAX website. 6/27/24 8:00 PM - Review of R45's EMR revealed the PCV20 pneumococcal vaccine that was administered on 2/20/24 was not documented.	F 883		

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F 883	Continued From page 81 7. Review of R51'sclinical record revealed: 12/22/22 - R51 was admitted to the facility. 2/20/24 - R51 received the PCV20 vaccine, which was documented in the DELVAX website. 6/27/24 8:00 PM - Review of R51's EMR revealed the PCV20 pneumococcal vaccine that was administered on 2/20/24 was not documented. There also was no documentation of a 2023/24 influenza vaccine or the declination of that vaccine provided by the facility. 8. Review of R60's clinical record revealed: 11/1/23 - R60 was admitted to the facility. 2/20/24 - R60 received the PCV20 vaccine, which was documented in the DELVAX website. 6/27/24 8:00 PM - Review of R51's EMR revealed the PCV20 pneumococcal vaccine that was administered on 2/20/24 was not documented. 9. Review of R223's clinical record revealed: 6/22/24- R223 was re-admitted to the facility. 2/20/24 - R223 received the PCV20 vaccine, which was documented in the DELVAX website. 6/27/24 8:00 PM - Review of R223's EMR revealed the PCV20 pneumococcal vaccine that was administered on 2/20/24 was not documented. There also was no documentation of a 2023 influenza vaccine or the declination of that vaccine provided by the facility.	F 883		

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F 883	Continued From page 82 6/28/24 8:49 AM - During an interview, E4 (Clinical Specialist) stated, "We had a pharmacy clinical in February. They came in and vaccinated the residents. They entered the vaccines in DELVAX. So if we put the vaccine dates in PCC under the immunization tab, we will be in compliance, right?" The facility failed to document in the EMR's the dates of pneumococcal vaccines for nine residents and the dates or declinations of influenza vaccines for five residents. 10. Review of R22's clinical record revealed: Centers for Disease Control and Prevention (CDC) Guidelines for Pneumococcal Vaccine Timing for Adults, 65 years, in order for an adult older than 65 years to be up-to-date/complete with the pneumococcal vaccination, a Prevnar20 (PCV20) vaccine should be administered 1 year after that adult received PCV13. CDC, April 2022 Facility Pneumococcal Vaccine Policy-" ...upon admission ...will be offered the vaccine series within thirty (30) days of admission to the facility unless medically contraindicated or the resident has already been vaccinated ...For residents who receive the vaccines ...will be documented in the resident's medical record ... Administration of the pneumococcal vaccine or revaccinations will be made in accordance with current Centers for Disease Control and Prevention (CDC) recommendations at the time of the vaccination." October 2019 4/27/21 - R22 was admitted to the facility with diagnoses, including but not limited to, atrial fibrillation, heart failure and dementia.	F 883		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085031	A. BUILDING _____ B. WING _____	C 07/02/2024

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F 883	Continued From page 83 6/27/24 -Review of R22's immunizations in the EMR revealed no documentation of a pneumococcal vaccine. DELVAX, Delaware's online immunization documentation system, documented that R22 received a Prevnar13 (13-valent pneumococcal conjugate) vaccine on 8/27/2015. The facility was unable to produce documentation of a recent pneumococcal vaccination, a medical contraindication, or a declination declaration for R22. Findings were reviewed during the exit conference on 7/2/24 at 2:15 PM with E1 (NHA), E2 (DON), E3 (ADON), E4 (Clinical Specialist) and two State of DE Ombudsmen (via telephone).	F 883		
F 947 SS=D	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff.	F 947		8/9/24

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F 947	Continued From page 84 §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on review of facility documentation and interview, it was determined that the facility failed to provide required in-service training (12 hours per year) for five out of five CNAs reviewed. Additionally, the facility failed to provide evidence of resident abuse prevention training for the five CNAs reviewed. Findings include: The facility was provided a list of five names of CNAs to provide documentation of the required 12 hours per year of CNA in-service training. 7/1/24 - A review of facility documentation submitted for staff training lacked evidence that E16, E17, E18, E19 and E20 met the 12 hours of annual in-service training required, including resident abuse prevention training. 7/2/24 10:00 AM - During an interview E2 (DON) stated that the facility was unable to provide documentation of the total number of required training hours, including resident abuse prevention training, for E16, E17, E18, E19 and E20. The facility failed to provide 12 hours of required annual in-service training's for five out of five staff CNA's. Findings were reviewed during the exit conference on 7/2/24 at 2:15 PM with E1 (NHA), E2 (DON), E3 (ADON), E4 (Clinical Specialist), and State of DE Ombudsmen (via telephone).	F 947	Corrective Action: "Corrective actions have been ensured by the Administrator and the Director of Nursing. The required In-service training will be completed by all nurse aides by the date of compliance. Identification of Other Residents: "Current Residents have the potential to be affected. "In order to prevent residents from being affected, the Human Resource Associate has completed a 100% audit of current employees to confirm compliance with C.N.A required annual training hours and Abuse prevention training. System Changes: "The Root Cause of the concern was a failure to adhere to the facility policy for Staff Development Program (rev. 5.2019). The facility policy for Staff Development Program (rev. 5.2019) was reviewed and found to meet professional standards. "The required In-service training and abuse prevention will be provided and completed by current nurse aides. "The facility system for managing the Staff Development Program has been updated to include a monthly review of compliance in the monthly Quality Assurance and Performance Improvement (QAPI) committee meeting.	

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F 947	Continued From page 85	F 947	"The administrator or designee will provide oversight to ensure ongoing compliance. Success Evaluation: "A Staff Development Program audit to ensure compliance with staff training requirements will be completed by the Director of Nursing or designee; Audits will have a goal of 100% compliance; Audits will be completed weekly until 100% compliance is achieved for 3 consecutive evaluations, then every other week until 100% compliance is achieved for 3 consecutive evaluations, and then monthly until 100% compliance is achieved for 3 consecutive evaluations. "The results of the audits will be provided to the QAPI Committee by the Director of HR monthly for the next 3 months to determine the need for continued monitoring.	