DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 03/18/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHIPLEY MANOR	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
F 000	INITIAL COMMENTS An unannounced complaint survey was conducted at this facility from March 4, 2015 through March 18, 2015. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other documentation as indicated. The facility census the first day of the survey was 66. The survey sample included (5) five residents and (1) sub sampled resident. Abbreviations used in this 2567 are as follows: ED - Executive Director; DON - Director of Nursing; ADON - Assistant Director of Nursing; SE - Staff Educator; RN - Registered Nurse; LPN - Licensed Practical Nurse; CNA - Certified Nurse's Aide; mg - milligrams; MAR - Medication Administration Record; TAR - Treatment Administration Record; Narcotic-Drug such as heroin, cocaine or marijuana that effects the brain, sometimes used for pain control; Morphine Sulfate-narcotic pain medication; Oxycodone-narcotic pain medication; NN - Nurses Notes.	F 000		5-19-15
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment	F 225	F 225 R 1 no longer resides at the facility. The Director of Nursing interviewed E-7 on 3/20/15 (the on-coming nurse) to obtain her witness statement. E-8 (C.N.A) no longer works at the facility. All Residents receiving narcotics are at risk for this deficient practice. Narcotic medication variances will be reviewed by the Executive Director to evaluate whether the investigation has been thoroughly completed.	5-19-15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kristen Bing Perrone
TITLE: Executive Director
(X6) DATE: 4-13-15

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

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F 225	Continued From page 1 of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, interview and review of facility documents as indicated, it was determined that the facility failed to do a thorough investigation when a discrepancy was discovered during the narcotic count reconciliation that was done every shift with 2 nurses. The facility failed	F 225	The Director of Nursing did not interview E-7 or E-8 (C.N.A). E-5 reported the variance to the Director of Nursing when the variance was found at 0700 during the medication count. The Staff Development Coordinator in-serviced the Director of Nursing on the "Internal Investigation" policy on 4/2/15. The Executive Director or designee will monitor narcotic medication variances to evaluate whether a thorough investigation has been completed. Monitoring will be daily until consistently reach 100% compliance over three consecutive evaluations then, three times a week until consistently reach 100% compliance at three consecutive evaluations, then once a week until consistently reach 100% compliance over three consecutive evaluations The sample will then be monitored one more time a month later to	

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F 225	Continued From page 2 to interview both nurses, who discovered the discrepancies with the narcotic count sheet for one (R1) out of 5 sampled residents. Additionally, the facility failed to interview a CNA, who may have had relevant knowledge. Findings include: Review of the facility's policy, dated 3/1/13 and entitled, "Internal Investigations of Reportable Resident Incidents" stated, "... Reportable Incidents Requiring An Investigation. The following qualify as Reportable Incidents/Accidents ... require prompt investigation ... Missing narcotics ... Conducting and Documenting Interviews ... is to compile a list of individuals who may have knowledge of the incident or allegation or who had contact with the resident or subject of the incident just prior to, during, or immediately after the incident. This may include the reporting or complaining party, others present during the incident, the individual accused ... and others who may not have been an eye witness to the alleged incident, but who may have relevant knowledge. The investigator (s) should conduct in person or telephone interviews with these individuals ... reduce each interview to writing using approved forms and ask the individual to review, make any necessary changes and sign the document ... Review and analyze all information collected; identify (and resolve) any conflicts or inconsistencies; ... and conduct any necessary re-interviews or follow-up ...". Review of the facility's "Medication Error Report" dated 1/9/15 included an interview, dated 1/19/15 from E5 (RN) that stated, "I was on break. The C.N.A [CNA] came to tell me, that he (resident) wanted pain medications. I said I'll be back from break in 10 minutes. The C.N.A said he didn't	F 225	ensure 100% compliance. The results of the monitoring will be forwarded to the QAPI committee. The QAPI committee will determine the need for further audits and or action plans.	

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F 225	Continued From page 3 want to wait and that someone else could give it to him. I gave the keys to (name of E6/LPN) to give the medication ... During the count with (name of E7/LPN), there was Morphine Sulfate (pain medication) 15 mg ER (Extended Release) 'missing'. When we got to the Oxy (Oxycodone) IR (Immediate Release) (pain medication), there was one too many ...". Review of the facility's "Medication Error Report" dated 1/9/15 included an interview dated 1/16/15 from E6 that stated, "At approximately 0415 (4:15 AM), C.N.A ...told me ... wanted his pain medication ... I told the C.N.A that (name of E6) was in the break room. The attendant went to tell her and ... came back ... with the medication cart keys. I administered the Oxycodone ... At approximately 0710 (7:30 AM), while giving report, (name of E5) ... told me that I had made a med [medication] error and that I gave the wrong pill ... This was after she counted with (name of E7) ...". During an interview on 3/17/15 at 9:15 AM, E2 (DON) confirmed that she had not interviewed either the CNA or the other nurse (E7). The facility failed to complete a thorough investigation when it failed to interview the CNA who was given the medication keys and the other oncoming nurse (E7), who verified that the narcotic count was in error.	F 225		
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality.	F 281	F 281 (1.) E-5 no longer is employed by the facility. E-6 was in-serviced to not leave any open lines on the controlled medication record. All Residents receiving narcotics are at risk for this deficient practice. 5-19-15 Controlled medication utilization records were evaluated to determine whether narcotic administration has been documented.	

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F 281	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on interview, record review,and review of other facility documents, it was determined that the facility failed to meet professional standards of quality for one (R1) out of five (5) sampled residents. The facility failed to document the administration of medications (narcotics) to R1 per the facility policies, failed to ensure that the keys to the medication carts were only available to licensed nurses, and lacked evidence that inservices for the use of IV pumps, were provided as per the facility policy. Additionally, one (SS1) sub sampled resident, who was observed during the medication pass, had a mislabeled medication. Findings include: Review of the facility's policy, dated 5/18/05 and entitled, "Documentation Systems Guidelines" stated, "... All charting will be done as soon as possible after the given event ... Late entry documentation: write the current date, time and 'late entry' for DATE Medications and treatments: The licensed nurse notes the time, date and dosage of all medications ... at the time they are administered and initials the note on the medication ... record ... the nurse who administers the medication ... must chart it on the resident's record ... The nurse administering the medication ... notes all PRN (as needed) orders on the medication ... record. The note must include the date, time, dosage, and reasons for giving the medication...". Review of the facility's policy, dated May 2010 and entitled, "...General Dose Preparation and Medication Administration" stated, "... After medication administration, Facility staff should take all measures required by Facility policy ...	F 281	E-6 failed to document the narcotic administered per the facility policy. The Staff Development Coordinator or designee will in-service the Licensed Nursing Staff on principles and guidelines related to documenting narcotics. The Director of Nursing or designee will monitor the controlled medication utilization records to evaluate whether documentation has occurred. Monitoring of the controlled medication utilization records will be daily until consistently reach 100% compliance then, they will be monitored three times a week until consistently reach 100% compliance at three consecutive evaluations, then they will be monitored once a week until consistently reach 100% compliance over three consecutive evaluations. The controlled medication utilization records will be monitored one more time a month later to ensure 100%	

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F 281	Continued From page 5 including, but not limited to the following: ... Document necessary medication administration ... information ... when medications are given ... If medications are refused, PRN medications ... on appropriate forms...". Review of the facility's policy, dated 6/1/10 and entitled, "Controlled Substances Management" stated, "... Declining Inventory Records (Controlled Medication Utilization Record/CMUR) are to be utilized for all medications listed in Schedule II-V (narcotics) ... Immediately after a dose of medication is removed from the medication container or blister pack the authorized nursing personnel administering the medication is to enter the following information on the declining inventory record: Date and time of administration; Dose administered ... Signature of ... nursing personnel administering the dose, Remaining doses...". Cross refer F309 Example 1 1.Review of R1's January 2015 MAR revealed that E5 [RN] had administered a dose of Oxycodone IR (Immediate Release) 15 mg at 1:30 AM on 1/9/15. Review of the "Medication Error Report", dated 1/9/15 included a statement from E5, dated 1/19/15 that stated, "... I did not sign out the Oxycodone IR at 0130 (1:30 AM) and (name of E6/RN) did leave a line for me to sign the narcotic out. I remember giving the light green pill but I don't remember checking how many pills were left in the blister pack". During a telephone interview on 3/17/15 at 2:23 PM, E5 confirmed that she had documented the	F 281	compliance. The QAPI committee will determine the need for further audits and or action plans. (2). R-1 no longer resides at the facility. Omnicare Pharmacy has scheduled in-services for infusion therapy. E-9 will be attending Omnicare infusion class on May 13 and 14 2015. The facility does not currently have any Residents on Intravenous infusion pumps. The licensed Nurses who have not attended the Omnicare infusion therapy in-services will be scheduled to attend. R-1 wanted his two intravenous antibiotics to run "at the same time." There was lack of education as to how to infuse two antibiotics simultaneously through one intravenous pump. Omnicare Pharmacy has scheduled infusion therapy in-services for Licensed Nurses to attend. Licensed Nurses, who have not attended infusion therapy classes, will be scheduled to attend.	

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F 281	Continued From page 6 dose of PRN Oxycodone IR medication on R1's January 2015 MAR (1/9/15 at 1:30 AM), but had not immediately documented that dose on the CMUR. E5 agreed that it should have been done immediately and if not, then a 'late entry' should have been documented. During an interview on 3/17/15 at 12:05 PM, E2 (DON) confirmed the findings. The facility failed to document narcotics administered per the facility's policies. 2. During an interview on 3/4/15 at 3:30 PM, R1 stated that the facility nurses did not know how to operate his IV (intravenous) pumps on several dates during his course of IV administered antibiotics. Review of the facility's policy, dated, 5/28/02 and entitled, "Medication Management Guidelines" stated, "... Intravenous Therapy ... The facility will maintain documentation verifying that licensed nurses have received training and in-service education on intravenous therapy ...". Review of the facility's investigation of R1's grievances, dated 1/15/15, included an allegation that (the name of E9, RN/Relief Supervisor) had "no knowledge" of how the IV pump operated. The investigation included a written statement, dated 1/15/15, from E9, that stated, "I have worked with these IV Pumps in my previous career at (name of hospital) on the medical surgical unit. I have over 2 years experience with this pump. I took the pump out of (name of resident/R1)'s room to show the other nurses how to use it...". The investigation included statements from 2	F 281	The Staff Development Coordinator or designee will track the Nurses attending the In-service. Monitoring will be daily until consistently reach 100% compliance over three consecutive evaluations then, three times a week until consistently reach 100% compliance at three consecutive evaluations, then once a week until consistently reach 100% compliance over three consecutive evaluations The sample will then be monitored one more time a month later to ensure 100% compliance. The results of the monitoring will be forwarded to the QAPI Committee for their review. (3). E-5 and E-8 no longer are employed at the facility. Narcotic Keys remain in the possession of a licensed nurse and are not given to any individuals who are not permitted to administer medications.	

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F 281	Continued From page 7 nurses (E14, LPN and E15, Nursing Supervisor), who stated that the issue was not the operation of the pump but rather, how to administer 2 antibiotics via one IV pump per R1's request. During an interview with E3 (ADON) on 3/18/15 at 11:40 AM, the survey team requested to review staff education/in-services on IV pumps. E3 stated that there were "No in-service" sheets regarding the operation/use of IV pumps. On 3/18/15 at approximately 4:30 PM, the findings were reviewed with E1 (ED), E2 and E3 at the exit conference. The facility failed to have documentation verifying that licensed nurses had received training and in-service education on intravenous therapy as per their facility policy. Cross refer F225 and F309 Example 1 3. Review of R1's medical record and corresponding facility documents revealed the following: Review of the 1/9/15 "Medication Error Report" included a statement from E6(LPN), dated 1/16/15 that stated, "... I told the C.N.A that (name of E5) was in the break room. The attendant went to tell her and the attendant came back to me with the medication cart keys...". Review of the facility's policy, dated, 5/28/02 and entitled, "Medication Management Guidelines" stated, "... The narcotic keys must remain in possession of a licensed nurse and may not be given to any individuals who are not permitted to administer medications...". During a telephone interview on 3/17/15 at 8:50 AM, E6 identified the CNA as E8. She confirmed that the "CNA" and "Attendant" that she included	F 281	E-5 failed to follow the Medication Management Guidelines. The Staff Development Coordinator or designee will in-service the Licensed Nursing Staff on Medication Management Guidelines. The Nursing Supervisor or designee will monitor narcotic key possession daily until reach 100% compliance over three consecutive evaluations then, three times a week until consistently reach 100% compliance at three consecutive evaluations, then once a week until consistently reach 100% compliance. Narcotic key possession will be monitored one more time a month later to ensure 100% compliance. (4). SS1's blister card label was corrected to match the medication administration record,	

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F 281	Continued From page 8 In her written statement was the same CNA (E8) and that E8 returned with the medication cart keys. She confirmed that this was against the facility's policy. During a telephone interview, on 3/17/15 at 10:58 AM, E8 (CNA) confirmed that E5 had given her the keys to the medication cart and she gave them to E6. During a telephone interview on 3/17/15 at 2:23 PM, E5 confirmed that she had given her keys to the medication cart to E8. She denied that this was her usual practice. On 3/18/15 at approximately 4:30 PM, the findings were reviewed with E1, E2 and E3 at the exit conference. The facility failed to ensure that the keys to the medication cart were only in the possession of authorized licensed nurses as per the facility policy. 4. During observations of the administration of medications on 3/10/2015 to SS1 inconsistency was revealed between the label of one prescribed medication and the MAR dated March 2015. According to the medication label, Hydralazine Hydrochloride (drug used to treat high blood pressure), one 10 mg tablet was prescribed for administration by mouth every eight hours to SS1 Although review of the MAR, dated March 2015 read, "Hydralazine 10mg by mouth twice a day", E7 (LPN) proceeded to pour then administer the medication to SS1at 9:53 AM. Review of the clinical record revealed "Physician Telephone Orders" dated 3/2/2015 that included an order to "D/C (discontinue) Hydralazine T.I.D. (three times	F 281	Residents with changes in their medication regimen are at risk for this deficient practice. E-7 was not aware that the blister card label had not been changed to reflect the new Hydralazine time change as documented on the medication record. Direction change stickers have been received from Omnicare Pharmacy to place on the Blister pack which states "direction change, refer to Med Cardex." The Staff Development Coordinator will in-service the Licensed Nurses on the "direction change labels."	

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F 281	Continued From page 9 a day or every eight hours)". Instead another order written on 3/2/2015 stated "Hydralazine 10 mg B.I.D. (twice a day)". However E7 proceeded to pour and administer the medication labeled "Hydralazine Hydrochloride 10mg tablet, one tab by mouth every eight hours" that was inconsistent with the MAR dated March 2015 and the current physician order dated 3/2/2015. According to the facility pharmacy policy entitled "General Dose Preparation and Medication Administration" the "...Facility staff should...verify each time a medication is administered that it is the correct medication, at the correct dose, at the correct route, at the correct rate, at the correct time for the correct resident...". The facility failed to ensure that a medication prescribed by the physician was properly labeled and available for administration at 8:00 AM on 3/10/2015 as scheduled for SS1. These findings were reviewed and confirmed with E1, E2, E3 and E4 (SE) on 3/18/2015 at 4:30 PM.	F 281	The Nursing Supervisor or designee will monitor blister pack labels to evaluate whether changes have been made. The monitoring will be daily until consistently reach 100% compliance over three consecutive evaluations then, three times a week until consistently reach 100% compliance at three consecutive evaluations, then once a week until consistently reach 100% compliance over three evaluations. The sample will be monitored one more time a month later to ensure 100% compliance. Results of these audits will be forwarded to the QAPI Committee. The QAPI Committee will determine the need for further audits and or action plans.	5-19-15
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on review of facility documents, staff interview, and clinical record review it was	F 309	F 309 R 1 no longer resides at the facility. R 1 was discharged to independent living on 3/6/15. The Director of Nursing completed an incident report on 1/9/15 for the medication variance. The Unit Manager completed a medication	

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F 309	Continued From page 10 determined that the facility failed to provide the care and services to maintain the highest practicable physical, mental and psychosocial well-being of one resident (R1) out of 5 sampled residents. The facility failed to ensure that multiple medications were administered as ordered. Findings include: Review of the facility's policy dated May 2010 and entitled, "10.2 Medication-Related Errors" stated, "... Administration time error: Facility administers to the resident a medication dose greater than sixty (60) minutes from its scheduled administration time ... Omission error: Facility fails to administer an ordered dose to the resident, unless refused by the resident or not administered because of recognized contraindication ...". Cross refer F225 1a. R1 was admitted to the facility on 9/3/14 and was alert and oriented and independent with decision making. During an interview on 3/4/15 at approximately 3:30 PM, R1 stated that he did not always get his medications as per the doctor's orders. R1 stated that on one occasion, a nurse had given him pain medication and in the morning, he requested that his PRN (as needed) pain medication be given. R1 stated that he was told he had already received his routine medication and could only have the prn order for pain. Additionally, he stated that there were other times when he was supposed to have a medication or treatment and it was not done. R1's doctor's orders included two different pain medications, Morphine ER (extended release) that was ordered routinely (45 mg in the evening	F 309	administration observation on 1/16/15 with E6. The Assistant Director of Nursing completed a medication administration observation on 1/23/15 with E5. The Director of Nursing evaluated Medication Administration Records for omissions in medication documentation and for proper documentation related to refusals of medications. The Medication Administration Records were evaluated to ensure vital signs were documented for medications having parameters. The Licensed Nurses failed to document whether medications were administered or refused. The Licensed Nurse failed to document vital signs on 10/214, 11/23/14 and on 11/25/14 at 2:00 pm. The Staff Development Coordinator will in-service the Licensed Nurse on principles and guideless of documentation related to medication administration and refusals. The Staff Development Coordinator will in-service the	

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	085031	A. BUILDING _____ B. WING _____	C 03/18/2015

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

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F 309	Continued From page 11 and 15 mg in the morning) and Oxycodone IR (immediate release) every 3 hours as needed for breakthrough pain relief. R1 had a doctor's TVO (telephone verbal order), dated 1/9/15 and timed 9 AM, that stated, "Do not administer Morphine Sulfate ER 15 mg @ (at) 0900 (9 AM) today only. Administer Oxycodone HCL (Hydrochloride) IR 15 mg one po (by mouth) tab (tablet) @ 0900[AM]". R1's NN, dated 1/9/15 and timed 3:15 PM stated the order as above and that R1 had received positive results from his PRN pain medication. Review of R1's January 2015 MAR revealed that on 1/9/15 at 9 AM, his morphine extended release was documented as "not given per MD (doctor)". R1 also received Oxycodone immediate release on at 1:30 AM, at 9:30 AM and 1 PM on 1/9/15. Review of the "Medication Error Report", dated 1/9/15, stated that on 1/9/15 at 4:20 AM, R1 was administered his routine (8 AM) dose of Morphine Sulfate ER 15 mg instead of his PRN dose of Oxycodone IR 15 mg. The type of error was listed as "wrong medication" and the reason for the error was listed as "Misread order". During an interview on 3/17/15 at 12:05 PM, E2 (DON) and E3 (ADON) confirmed the findings. E2 stated that she had seen R1 on the morning of 1/9/15 and asked him if his pain level was any different than on other days. E2 stated that R1 described his pain level "as the same as always." E2 stated that she went a second time, about 12 noon on 1/9/15 and offered R1 pm pain medication which he declined.	F 309	Licensed Nursing Staff on documentation of vital signs when ordered by the Physician. The Assistant Director of Nursing or designee will audit Medication Administration Records to evaluate documentation and administration of medications and vital sign documentation daily until three consecutive evaluations reaches 100% success, then Medication Administration Records will be monitored three times a week until consistently reach 100% for three consecutive evaluations, then Medication Administration Records will be monitored once a week until consistently reach 100% over 3 consecutive evaluations. Finally, Medication Administration records will be audited one more time a month later to determine that the deficiency cited remains at 100%. Results of these Medication Administration Record audits will be forwarded to the QAPI committee.	

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F 309	Continued From page 12 1b.Review of R1's clinical record, including doctor's orders, MARs and NN; revealed the following: - R1 had a doctor's order, dated 9/11/14, for Clonidine (used to treat high blood pressure)0.1 mg by mouth three times a day (timed for 8 AM, 2 PM and 10 PM) with parameters to hold (not administer) the medication if the systolic [the top number of the blood pressure reflects pressure in the vessels when the heart is beating] blood pressure was less than 100 or the heart rate was less than 60. Review of R1's clinical record (October and November 2014 MARs and NN) lacked evidence that this medication was administered or that it was offered and refused on 10/2/14 at 2 PM, on 11/23/14 at 2 PM and on 11/25/14 at 2 PM. Additionally, there was no evidence that vital signs were done at these times; - R1 had a doctor's order, dated 10/8/14, for Morphine Sulfate ER 30 mg by mouth every evening and timed for 9 PM. Review of R1's clinical record (November 2014 MARs and NN) lacked evidence that this medication was administered or that it was offered and refused on 11/7/14 at 9 PM; - R1 had a doctor's order, dated 9/25/14, for Phenobarbital (used to treat seizures) 32.4 mg by mouth three times a day (timed for 8 AM, 2 PM and 10 PM). Review of R1's clinical record (November 2014 MARs and NN) lacked evidence that this	F 309	The QAPI Committee will determine the need for further audits and or action plans.	

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F 309	Continued From page 13 medication was administered or that it was offered and refused on 11/7/14 at 10 PM; - R1 had a doctor's order, dated 9/15/14, for Miralax (used to treat constipation) 1 capful (17 grams) with fluid or water every morning (timed for 8 AM). Review of R1's clinical record (November 2014 MARs and NN) lacked evidence that this medication was administered or that it was offered and refused on 11/8/14 at 8 AM; - R1 had a doctor's order, dated 1/16/15, for Tamulosin (used to treat the prostate) 0.4 mg by mouth once a day (timed for 8 AM). Review of R1's clinical record (February 2015 MARs and NN) lacked evidence that this medication was administered or that it was offered and refused on 2/11/15 and 2/12/15 at 8 AM; - R1 had a doctor's order, dated 1/16/15, for Zinc Sulfate (supplement) 220 mg by mouth twice daily (timed for 2 PM and 8 PM). Review of R1's clinical record (February 2015 MARs and NN) lacked evidence that this medication was administered or that it was offered and refused on 2/25/15 and 2/27/15 at 2 PM; - R1 had a doctor's order, dated 1/16/15, for Lisinopril (used to treat high blood pressure) 10 mg by mouth once a day (timed for 8 AM). Review of R1's clinical record (February 2015 MARs and NN) lacked evidence that this	F 309		

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F 309	Continued From page 14 medication was administered or that it was offered and refused on 2/2/15 and 2/11/15 at 8 AM; - R1 had a doctor's order, dated 1/16/15, for Morphine Sulfate ER 15 mg by mouth every morning and timed for 8 AM. Review of R1's clinical record (February 2015 MARs and NN) lacked evidence that this medication was administered or that it was offered and refused on 2/2/15, 2/5/15, 2/11/15, 2/19/15 and 2/22/15 (5 days) at 8 AM; - R1 had a doctor's order, dated 1/16/15, for one multivitamin (supplement) by mouth every morning and timed for 2 PM. Review of R1's clinical record (February 2015 MARs and NN) lacked evidence that this medication was administered or that it was offered and refused on 2/25/15 at 2 PM; - R1 had a doctor's order, dated 1/16/15, for folic acid (supplement) by mouth every morning and timed for 2 PM. Review of R1's clinical record (February 2015 MARs and NN) lacked evidence that this medication was administered or that it was offered and refused on 3/3/15 at 2 PM. On 3/18/15 at approximately 4:30 PM, the findings were reviewed with E1 (ED), E2 and E3 at the exit conference. The facility failed to ensure that R1 received his medications as ordered on multiple occasions.	F 309		
F 314	483.25(c) TREATMENT/SVCS TO	F 314	F 314 R-1 no longer resides at the facility. He was discharged to independent living on 3/6/15 with a healed surgical flap.	

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F 314 SS=E	Continued From page 15 PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, it was determined that for one (R1) out of 5 sampled residents, who was admitted with pressure ulcers (sore area of skin that develops when the blood supply to it is cut off due to pressure), the facility failed to provide the necessary treatments and services to promote healing as ordered by the physician. Findings include: R1 was admitted to the facility on 9/3/14 with pressure ulcers to his left and right ischiums (part of the hip bones on which the body rests when sitting), sacrum (tailbone area) and left heel. R1 was alert and oriented and independent with decision making. R1 was care planned for refusals of care. During an interview on 3/4/15 at approximately 3:30 PM, R1 stated that he did not always get his treatments done as per the doctor's orders. Review of R1's clinical record, including doctor's orders, TARs and NN, revealed the following:	F 314	The Director of Nursing performed an audit of Treatment Administration Records to evaluate whether treatments were being done as per Physician order The Licensed Nurses failed to administer or failed to document offering and refusal on 9/26/14, 9/27/14, 10/6/14, 10/8/14, 11/2514, 11/30/14, and 12/2/14. The Staff Development Coordinator will in-service the Licensed Nurses on administration of treatments per Physician Orders and documentation of refusals of treatments. The Director of Nursing or designee will monitor the treatment administration records to evaluate whether treatments are being administered and or offering and refusals are being documented. Monitoring of the treatment records will be daily until consistently reach 100% compliance then, they will be monitored three times a week until consistently reach 100% compliance at three consecutive evaluations,	5-19-15

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F 314	Continued From page 16 - R1 had a doctor's order, dated 9/19/14 and timed 2:35 PM, for his left and right ischial and sacral wounds to be cleansed with NSS (normal saline solution), patted dry, packed lightly with a NSS soaked Kling (type of dressing/bandage), covered with an ABD (abdominal) pad (type of dressing) and secured using Medipore (soft cloth medical adhesive) tape daily. Review of R1's September 2014 TAR and NN lacked evidence that these treatments were administered or that they were offered and refused on 9/26/14 and 9/27/14 on the 7-3 (day) shift; - R1 had a doctor's order, dated 9/4/14 and timed 4 PM, to discontinue all previous treatment orders and to cleanse his left heel wound with NSS, pat dry, apply layer of Santyl (prescription ointment that cleans wounds to clear the way for healthy tissue) to wound bed cover with a wet to dry gauze and wrap with Kling daily. Review of R1's October 2014 TAR and NN lacked evidence that these treatments were administered or that they were offered and refused on 10/6/14 and 10/8/14 on the 7-3 shift; - R1's POS (Physician's Order Sheet), dated 11/3/14, included an order to cleanse the left ischial wound with NSS, pat dry and apply Aquacell AG (wound dressing with silver) to the wound bed and cover with foam bordered dressing daily. Review of R1's November and December 2014 TARs and NN lacked evidence that any of these	F 314	Then once a week until consistently reach 100% compliance over three evaluations. The sample will be monitored one more time a month later to ensure 100% compliance. Results of these audits will be forwarded to the QAPI Committee. The QAPI Committee will determine the need for further audits and or action plans.	

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F 314	Continued From page 17 treatments were administered or that they were offered and refused on 11/25/14, 11/30/14, and 12/2/14 on the 7-3 shift; - R1's POS, dated 11/3/14, included an order to cleanse the right ischial wound with NSS, pat dry and apply Aquacell AG to the wound bed and cover with foam bordered dressing daily. Review of R1's November and December 2014 TARs and NN lacked evidence that any of these treatments were administered or that they were offered and refused on 11/25/14, 11/30/14 and 12/2/14 on the 7-3 shift; - R1's POS, dated 11/3/14, included an order to cleanse the sacral wound with NSS, pat dry and apply Aquacell AG to the wound bed and cover with foam bordered dressing daily. Review of R1's November and December 2014 TARs and NN lacked evidence that any of these treatments were administered or that they were offered and refused on 11/25/14, 11/30/14, and 12/2/14 on the 7-3 shift; - R1's POS, dated 11/3/14, included an order to cleanse the left heel with NSS, pat dry and apply Aquacell AG to the wound bed and cover with allevyn foam bordered dressing (dressing that absorbs excess fluid but maintains the wound surface in a moist condition providing a micro-environment that is conducive to healing) and Kling daily. Review of R1's November and December 2014 TARs and NN lacked evidence that any of these treatments were administered or that they were offered and refused on 11/25/14, 11/30/14 and 12/2/14 on the 7-3 shift;	F 314		

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F 314	Continued From page 18 On 3/18/15 at approximately 4:30 PM, the findings were reviewed with E1 (ED), E2 (DON) and E3 (ADON) at the exit conference. The facility failed to ensure that R1 received his treatments as ordered on multiple occasions.	F 314	F 514 R 1 no longer resides at the facility. He was discharged to independent living on 3/6/15.	5-19-15
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete and accurately documented for one (R1) out of 5 sampled residents. Findings include: Review of the facility's policy, dated 5/18/05 and entitled, "Documentation Systems Guidelines" stated, "... All charting will be done as soon as possible after the given event ... Late entry documentation: write the current date, time and	F 514	All Residents having recommendations made by consulting physicians have the potential to be affected by this deficient practice. All Residents with physician orders for discontinued colostomy bags are at risk for this deficient practice. The Licensed Nurse failed to transcribe the complete Physician order written by the Wound Care on 1/9/15. The Licensed Nurse failed to discontinue the physician order for R1's one-piece Hollister colostomy. The Staff Development Coordinator will in-service the Licensed Nurses on complete transcription of Consulting Physician orders. The Staff Development Coordinator will in-service the Licensed Nurses on transcription of discontinued physician orders.	

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 03/18/2016

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F 514	Continued From page 19 'late entry for DATE' ... Medication and Treatments: The licensed nurse notes the time, date and dosage of all medications and treatments at the time they are administered and initials the note on the medication and/or treatment record ... If a scheduled medication/treatment was withheld or not given as ordered, the nurse documents this and lists the reason(s) for the resident not receiving the medication/treatment...". 1A. R1's clinical record revealed a doctor's order, dated 1/9/15 and timed 8 PM that stated, "cont (continue) clinitron (air flotation mattress that minimizes pressure) bed; no sitting; no flex at waist, no knee to chest per wound care ...". Review of R1's January 2015 TAR revealed this order was transcribed as, "cont clinitron bed" and "No sitting". The facility failed to transcribe the complete order on the January 2015 TAR. 1B. R1's clinical record revealed a doctor's order, dated 1/22/15 and timed 4 PM, that stated, "D/C (Discontinue) one piece hollister (brand name) colostomy (surgical opening of the colon or bowel on the surface of the abdomen where fecal contents collect in an external appliance) bag per resident request". Review of R1's January 2015 TAR lacked evidence that this order had been discontinued. On 3/18/15 at approximately 4:30 PM, the findings were reviewed with E1 (ED), E2 (DON), E3 (ADON) and E4 (SE) at the exit conference.	F 514	The Care Coordinator or designee will perform audits of the Treatment administration records to evaluate complete transcription of Consulting physician orders and orders and to evaluate discontinuation of physician orders. This audit will be done daily until 100% compliance over three consecutive evaluations, then they will be done three times a week until 100% compliance at three consecutive evaluations, then they will be done once a week until consistently reach 100% compliance over three consecutive evaluations. Audits will occur one more time a month later to ensure 100% compliance. The results of this audit will be forwarded to the QAPI committee for their review. The QAPI committee will determine the need for further audits or action plans.	

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

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Shipley Manor

DATE SURVEY COMPLETED: March 18, 2015

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced complaint survey was conducted at this facility from March 4, 2015 through March 18, 2015. The deficiencies contained in this report are based on observations, interviews, review of resident's clinical records and review of other documentation as indicated. The facility census the first day of the survey was 66. The survey sample included (5) five residents and (1) sub sampled resident.	On 2/14/15 and 2/15/15 the required daily care hours were not met. Facility is unable to correct the action. The Director of Nursing or designee reviews staffing on a daily basis to evaluate compliance with the daily care hours. The facility is in compliance with the required 3.28 daily care hours. On 2/13/15 the staffing schedule was reviewed for compliance with the daily care hours. On 2/14/15 and on 2/15/15 the facility had unexpected and unavoidable Nurse and C.N.A call offs. On both days, two of the C.N.A's calling off were scheduled for both the 7-3 and 3-11 shifts. On 2/14/15, the facility had two staff nurses call off on 3-11 shift. The Supervisor on 7-3 and on 3-11 placed multiple calls to all full time, part time and PRN staff to attempt to seek coverage. The Director of Nursing came in on 3-11 to cover a vacant shift. The schedule will be reviewed on every shift to evaluate whether the facility is compliant with the daily care hours.	5-19-15
3201 3201.1.0 3201.1.2	**Regulations for Skilled and Intermediate Care Facilities** **Scope** **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.**		

Provider's Signature [signature] Title Executive Director Date 4-14-15

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NAME OF FACILITY: Shipley Manor

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SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	This requirement is not met as evidenced by: Cross refer to CMS 2567-L, survey date completed March 18, 2015: F225, F281, F309, F314, and F514. **16 Del. C., 1162 Nursing Staffing:** (c) By January 1, 2002, the minimum staffing level for nursing services direct caregivers shall not be less than the staffing level required to provide 3.28 hours of direct care per resident per day, subject to Commission recommendation and provided that funds have been appropriated for 3.28 hours of direct care per resident for Medicaid eligible reimbursement. Nursing staff must be distributed in order to meet the following minimum weekly shift ratios: RN/LPN CNA* Day 1 nurse per 15 residents 1 aide per 8 residents Evening 1:23 1:10 Night 1:40 1:20 * or RN, LPN, or NAIT serving as a CNA. (g) The time period for review and determining compliance with the staffing ratios under this chapter shall be one (1) week. **The law was not met as evidenced by:** Three weeks of facility staffing, covering the period of 9 February 2015 through 1 March 2015 inclusive, were reviewed to verify compliance with Delaware Nursing Home Staffing Laws, commonly known as Eagles' Law. The review consisted of data entered	The facility is actively interviewing R.N's for PRN positions. R.N. PRN's will be utilized when there are unexpected and unavoidable call offs. The Nursing Supervisor will review the daily staffing schedule daily until 100% compliance over three consecutive evaluations, then the schedule will be reviewed three times a week until 100% compliance at three consecutive evaluations, then the schedule will be done reviewed once a week until consistently reach 100% compliance The schedule will be reviewed one more time a month later to ensure 100% compliance with staffing. . The results of this audit will be forwarded to the QAPI committee for their review. The QAPI committee will determine the need for further audits or action plans.	

Provider's Signature _____ Title Executive Director Date 4-14-15

NAME OF FACILITY: Shipley Manor

DATE SURVEY COMPLETED: March 18, 2015

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	on the DLTCRP Staffing Worksheets by Shipley Manor staff, and signed by the Administrator. The **TWO (2)** citations hereon result from that work. Shipley Manor was found noncompliant with the required 3.28 daily care hours per resident on the following **TWO (2)** dates. The care hours attained by the provider for each date are in parentheses. Saturday 14 February 2015 @ (3.01) Sunday 15 February 2015 @ (2.82)		

Provider's Signature _____ Title Executive Director Date 4-14-15