STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085012	A. BUILDING _____ B. WING _____	12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY HEALTHCARE & REHAB CENTER	801 N. BROOM STREET WILMINGTON, DE 19806

(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 survey was conducted at this facility from December 11, 2018 through December 14, 2018. The facility census the first day of the survey was 92. An emergency preparedness survey was also conducted during the same time period. There were no emergency preparedness deficiencies identified based on observation and interviews.	E 000		
F 000	INITIAL COMMENTS An unannounced annual survey was conducted at this facility from December 11, 2018 through December 14, 2018. The deficiencies contained in this report are based on the observations, interviews, review of clinical records, and other facility documentation as indicated. The facility census the first day of the survey was 92. The survey sample size was 43. Abbreviations/definitions used in this report are as follows: AD - Activities Director; ADON - Assistant Director of Nursing; CNA - Certified Nurse's Aide; DOH - Director of Housekeeping; DON - Director of Nursing; FMD - Facility Maintenance Director; FSD - Food Service Director; LPN - Licensed Practical Nurse; MD - Medical Doctor; NHA - Nursing Home Administrator; RD - Registered Dietician; RN - Registered Nurse; RNAC - Registered Nurse Assessment Coordinator; SW-social worker/social service;	F 000		

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

Electronically Signed | 01/06/2019

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F 000	Continued From page 1 UN - unit manager; ADL - Activities of Daily Living; AIMS (Abnormal Involuntary Movement Scale) - a rating scale to measure involuntary movements of the face, mouth, trunk, or limbs known as tardive dyskinesia that sometimes develops as a side effect of long-term treatment with antipsychotic medications; Antidepressant - drug to counter depression; Antipsychotic- class of medication used to manage psychosis, an abnormal condition of the mind involving a loss of contact with reality and other mental and emotional conditions; Anxiety - extreme nervousness; BM (bm)- bowel movement; Bowel obstruction - is a mechanical or functional obstruction of the intestines which prevents the normal movement of the products of digestion; Delusional Disorder - a mental disorder marked by consistent delusions (beliefs held with strong conviction despite evidence to the contrary); Dementia - a severe state of cognitive impairment characterized by memory loss, difficulty with abstract thinking, and disorientation OR loss of mental functions such as memory and reasoning that is severe enough to interfere with a person's daily functioning; Depression - extreme sadness; Dialysis - cleansing of the blood by artificial means when kidneys have failed; eMAR/MAR - electronic Medication Administration Record/Medication Administration Record; Enema - insertion of fluid into the bowel to stimulate a bowel movement; End-Stage Renal Disease - (ESRD) disease where the kidneys stop working; Extensive assist - resident involved in activity,	F 000		

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F 000	Continued From page 2	F 000		

staff provide weight-bearing support;
Fluid overload - too much fluid in the blood;
Hydralazine - a medication used to treat high blood pressure;
Hypoxia / Hypoxic - inadequate cellular oxygenation OR deficiency in amount of oxygen reaching body tissues;
Hypertension - high blood pressure; leading cause of stroke;
Hyperkalemia - or high blood potassium is a condition caused by abnormally high levels of potassium in the blood. Symptoms of hyperkalemia include nausea, muscle weakness, and tingling sensations;
IDT- interdisciplinary team;
lbs.- pounds; unit of measuring for solid materials;
Major Depressive Disorder (MDD) - a mental disorder with feelings of sadness or a mood disorder that causes a persistent feeling of sadness and loss of interest that affects how you feel, think and behave;
MDS - Minimum Data Set/standardized assessment tool used in Long Term Care facilities;
MG (mg)- milligrams;
ML (ml)- milliliters;
MRR- Medication Regimen Review/monthly review of residents medications to find any irregularities or findings inconsistent with usual, proper, accepted, or right approaches to providing pharmaceutical services or that impede or interfere with achieving the intended outcomes of those services;
Nectar - A liquid, that has been thickened to a consistency of tomato juice;
Pain Scale - 1-10. The most common scale for pain. The patient to identifies their pain between one to ten, with ten being the worst pain

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F 000	Continued From page 3 imaginable and one being no pain at all; Peripheral Vascular Disease - (PVD) refers to diseases of the blood vessels - arteries and veins OR common circulatory problem in which narrowed arteries reduce blood flow to your limbs; post-after; PRN-as needed; Psychosis - loss of contact/touch with reality; Remeron - an antidepressant medication; Seroquel - an antipsychotic medication; TAR- treatment administration record: Tylenol - the brand name of acetaminophen which is a pain reliever. It is used to treat mild pain and fever;	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the	F 550		1/16/19

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F 550	Continued From page 4 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 subpart. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that for three (R29, R47, and R70) out of 43 sampled residents, the facility failed to promote care in a manner and environment that maintained or enhanced their dignity and respect in full recognition of their individuality. Findings include: During a dining observation on the third floor hallway on 12/11/18 at 12:24 PM, E3 (RN Unit Manager) referred to R29, R47, and R70 as "feeders" when explaining to the surveyor why these residents did not currently have a tray. E3 stated that the "feeder" trays had not come up to floor yet. The facility failed to promote care in a manner and environment that maintained or enhanced	F 550	A. All findings identified during survey were corrected immediately by (E1) DON on 12/27/18.¿ R29, R47 and R70 were not negatively impacted by the deficient practice. E3 (RN Unit Manager) was re-educated immediately on dignity and respect in full recognition of residents¿individuality. B. All residents have the potential to be affected and the right to be treated with respect and dignity and care for in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident s individuality. C. Staff Educator/designee will educate	

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F 550	Continued From page 5 R29, R47, and R70's dignity and respect in full recognition of their individuality when a staff member referred to them as "feeders". During the Exit Conference on 12/14/18 at approximately 2:15 PM, findings were reviewed with E1 (NHA) and E2 (DON).	F 550	all staff on resident rights to promote care in a manner and environment that maintains or enhances dignity and respect in full recognition of their individuality.¿ During meal times, the nursing staff will assist those residents who require assistance with meals and receive education to not refer to any resident as feeders.¿ D. DON/designee will audit during meal times five days per week until three consecutive 100% compliance is achieved. Then, three times a week until we consistently reach 100% compliance over three consecutive evaluations. Then once a week until we consistently reach 100% compliance over three consecutive evaluations. Then, one more time a month later, if we are still at 100% compliance we will conclude that we have successfully addressed the deficient practice.¿ The findings will be analyzed in the QA meetings to ensure regulatory compliance.	
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 2 (R39 and R87) out of 92	F 558	A. All findings identified during the survey were corrected immediately by (E2) DON	1/16/19

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F 558	Continued From page 6 observed residents the facility failed to ensure the call bell was within the residents' reach. Findings include: 1. 12/12/18 from 9:47 AM to 10:13 AM - During medication pass observation with E19 (RN), R39's call bell was hanging from the right side bed rail and out of reach of the resident. Before leaving the room E19 pulled the call bell up towards the resident and almost immediately, the call bell started slipping down the side of the bed. E19 exited the room. The surveyor asked the resident to reach the call bell and R39 was unable to reach the call bell. 2. 12/13/18 at 9:20 AM - R87 was observed in bed. The call bell was hanging over and wrapped around the left side bed rail. R87 had a call bell device, which was activated by pressure by the resident. R87 was asked by the surveyor, if they could reach the call bell and R87 stated "no". The surveyor asked if the resident needed the call bell on his chest so pressure could be applied from R87's hands and R87 stated "yes". 12/13/18 at 10:06 AM - R87's call bell remained in the same place. A nurse from hospice was at the bedside. 12/13/18 at 10:30 AM - R87's call bell was observed to be on the chest and functional for the resident. The above findings were reviewed with E1 (NHA) and E2 (DON) on 12/14/18, during the exit conference starting at 2:15 PM.	F 558	and clips were added to R39 and R87 call bells to ensure resident could engage and press the call bell when services are needed with frequent monitoring of the nursing staff.¿¿ R39 and R87 were not negatively impacted by the deficient practice. B. Residents have the potential to be affected. C. E2 DON/Staff Educator or designee will educate nursing staff and CNAs, including E19 and the hospice bedside nurses on the placement of call bells to ensure the call bells are within reach, engaged by the resident at all times and functioning.¿ The E2 DON/Staff Educator will designate the Unit Managers to make rounds on all residents to monitor that call bells are within reach. Nursing staff will also be educated the right for residents to reside and receive services in the facility with reasonable accommodations of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents.¿ D. DON/designee will audit that the call bells are within reach of all residents five days per week until three consecutive 100% compliance is achieved. Then, three times a week until we consistently reach 100% compliance over three consecutive evaluations. Then, once a week until we consistently reach 100% compliance over three consecutive evaluations. Then, one more time a	

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F 558	Continued From page 7	F 558	month later, if we are still at 100% compliance we will conclude that we have successfully addressed the deficient practice. The findings will be analyzed in the QA meetings to ensure regulatory compliance.	
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced	F 561		1/16/19

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F 561	Continued From page 8 by: Based on interview, record review, and review of other facility documentation it was determined that for two (R9 and R78)) out of 43 sampled residents the facility failed to provide the necessary services to ensure that showers were received as scheduled, based on the residents preference. Findings include: 1. Review of R78's clinical record revealed: 8/23/18 - The quarterly MDS assessment documented that R78 required extensive assistance of two plus staff for bathing. 10/1/18-10/31/18 - The CNA record documented that R78 was scheduled for showers, two times a week on Mondays and Thursdays. Record review lacked evidence that R78 was offered showers for two of the nine scheduled showers (10/8/18 and 10/11/18). 11/14/18 - The annual MDS assessment documented that R78 continued to require extensive assistance of two plus staff for bathing. 11/1/18-11/30/18 - The CNA record documented that R78 was scheduled for showers, two times a week on Mondays and Thursdays. Record review lacked evidence that R78 was offered showers for one of the seven scheduled showers (11/19/18). 12/1-12/10/18 - The CNA record documented that R78 was scheduled for showers, two times a week on Mondays and Thursdays. Record review lacked evidence that R78 was offered showers for one of the five scheduled showers (12/3/18).	F 561	1. A. R78 was reassessed/interviewed by (E2) DON on 12/17/18 for corrective measure to ensure shower schedule was honored based on resident preference to have showers two times a week on Mondays and Thursday around 6am with extensive assistance of two plus staff for bathing. R78 did not have any adverse effects from missing the showers. B. Residents have the potential to be affected. C. E2 DON reviewed and updated the shower schedules for all residents on the CNA task list meeting each resident s preference. E2 DON/Staff Educator or designee will educate all nursing staff and CNAs on Self-Determination and Right to make choices about aspects of his or her life in the facility that are significant to the resident.¿ During a resident s admission, the Nursing Supervisor/designee completing the admission shall review shower preferences and update task list bath or shower personalized to each residents shower days and time. During the annual review, the designee will re-interview the resident and update preferences as necessary. Staff Educator or designee will educate the nursing staff and CNAs on proper documentation of refusals of showers to meet each resident s preferences. All nursing staff shall be in-serviced. D. DON/designee will audit residents who	

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F 561	Continued From page 9 12/14/18 at approximately 1:00 PM - The above findings were confirmed with E2 (DON). 2. Review of R9's clinical record revealed: 9/11/18- A Quarterly MDS revealed R9 was cognitively intact, and was independent with bathing, requiring setup help only. 10/30/18-11/6/18- Review of R9's October and November Documentation Survey Reports revealed that R9 had a shower on 10/30/18, and did not receive another shower until 11/6/18 (one week later). 11/20/18-11/26/18- Review of R9's November Documentation Survey Report revealed that R9 had a shower on 11/20/18, and did not receive another shower until 11/26/18 (6 days later). 12/11/18 at 9:06 AM- During an interview, R9 stated that she was scheduled to receive two showers a week, on Tuesdays and Fridays during midnight shift, but was not receiving them due to staff stating they did not have enough time. The facility failed to provide R9 with showers in accordance with her twice weekly shower schedule. The above findings were reviewed with E1 (NHA) and E2 (DON) on 12/14/18, during the exit conference starting at 2:15 PM.	F 561	are care planned for showers to ensure shower was completed and proper documentation was done in POC five days per week until three consecutive 100% compliance is achieved. Then, three times a week until we consistently reach 100% compliance over three consecutive evaluations. Then, once a week until we consistently reach 100% compliance over three consecutive evaluations. Then, one more time a month later, if we are still a 100% compliance we will conclude that we have successfully addressed the deficient practice. The findings will be analyzed in the QA meetings to ensure regulatory compliance. 2. A. R9 was given a shower and did not have any adverse effects from missing the showers. B. Residents have the potential to be affected. C. E2 DON reviewed and updated the shower schedules for residents on the CNA task list meeting each resident s preference. E2 DON/Staff Educator or designee will educate all nursing staff and CNAs on Self-Determination and Right to make choices about aspects of his or her life in the facility that are significant to the resident.¿ During a resident s admission, the Nursing Supervisor/designee completing the admission shall review shower preferences and update task list	

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F 561	Continued From page 10	F 561	bath or shower personalized to each residents shower days and time. During the annual review, the designee will re-interview the resident and update preferences as necessary. Staff Educator or designee will educate the nursing staff and CNAs on proper documentation of refusals of showers to meet each resident s preferences. All nursing staff shall be in-serviced. D. DON/designee will audit residents who are care planned for showers to ensure shower was completed and proper documentation was done in POC five days per week until three consecutive 100% compliance is achieved. Then, three times a week until we consistently reach 100% compliance over three consecutive evaluations. Then, once a week until we consistently reach 100% compliance over three consecutive evaluations. Then, one more time a month later, if we are still a 100% compliance we will conclude that we have successfully addressed the deficient practice. The findings will be analyzed in the QA meetings to ensure regulatory compliance.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable	F 656		1/16/19

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F 656	Continued From page 11 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. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to develop and implement a comprehensive care plan with	F 656	1. A. R47 s clinical record cannot be retroactively corrected. R47 was not	

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F 656	Continued From page 12 measurable goals for two (R47 and R60) out of 43 sampled residents. For R47, the facility failed to implement a depression care plan. For R60, the facility failed to implement a care plan for R60's dialysis refusals. Findings include: 1. Review of R47's clinical record revealed: R47 was admitted to the facility on 12/9/14. Review of R47's diagnoses revealed that R47 had a diagnosis of Major Depressive Disorder (MDD). Review of R47's physician orders revealed that R47 was ordered the medication Remeron for MDD starting on 1/28/17. R47's care plan lacked evidence that a depression care plan was developed after R47 was diagnosed with MDD and began receiving antidepressant medication. During an interview on 12/13/18 at 3:45 PM, E2 (DON) confirmed that R47 had a diagnosis of MDD and was receiving the antidepressant Remeron, but was not care planned for depression. During the Exit Conference on 12/14/18 at approximately 2:00 PM, findings were reviewed with E1 (NHA) and E2 (DON). 2. Review of R60's clinical record revealed: R60 was admitted to the facility on 7/30/18 with diagnoses that included end stage renal disease. A care plan was developed for R60 on 8/2/18,	F 656	adversely affected by not having a care plan developed for depression disorder. E2/ DON immediately updated R47 s depression care plan with measureable goals. B. Residents have the potential to be affected. C. E2 DON reviewed all residents being treated for depression to ensure a depression care plan is developed and implemented after diagnosed with Major Depressive Disorder (MDD) and reviewed medication orders. E2 DON/ Staff Educator or designee will educate nursing staff on developing on developing and implementing a comprehensive care plan with measureable goals for residents diagnosed of Major Depressive Disorder (MDD) and the medication administered per MD order with interventions in put in place, if necessary. D. DON/designee will audit the care plans of residents who are currently being treated for depression or have depressed mood to ensure a care plan was developed with interventions five days per week until three consecutive 100% compliance is achieved. Then, three times a week until we consistently reach 100% compliance over three consecutive evaluations. Then, once a week until we consistently reach 100% compliance over three consecutive evaluations. Then, one more time a month later, if we are still at 100% compliance we will conclude that we have successfully addressed the	

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F 656	Continued From page 13 stating that R60 required dialysis. Interventions included encouraging R9 to go to scheduled dialysis appointments. Review of R60's progress notes revealed that it was documented that R60 refused to go to dialysis on 9/15/18 and 9/27/18. R60's care plan lacked evidence that a care plan was developed in September or October for R60's dialysis refusals. Review of R60's progress notes revealed that on 11/6/18 she again refused to go to dialysis. After this refusal, a care plan was developed on, 11/7/18, stating that R60 was non-adherent with being dialyzed. Interventions included to encourage compliance with dialysis schedule, explain risks of not receiving dialysis, and report refusals of dialysis to MD. The facility failed to develop and implement a care plan for R60's dialysis refusals after R60 refused dialysis two times during the month of September. A care plan was not developed for R60 until after her third refusal in November. During the Exit Conference on 12/14/18 at approximately 2:00 PM, findings were reviewed with E1 (NHA) and E2 (DON).	F 656	deficient practice. The findings will be analyzed in the QA meetings to ensure regulatory compliance. 2. A. R60 did not have any adverse effects from refusing dialysis. E2/DON immediately reviewed care plan developed on 11/7/18 for R60 to ensure interventions were in place for refusing dialysis. B. No other resident s impacted. C. E2 DON/ Staff Educator or designee will educate nursing staff on developing and implementing a care plan after the first refusal to encourage compliance with dialysis schedule, explaining the risks of not receiving dialysis, and report refusals of dialysis to MD. D. DON/designee will audit all residents on dialysis for care plan and interventions after any refusal or dialysis care five days per week until three consecutive 100% compliance is achieved. Then, three times a week until we consistently reach 100% compliance over three consecutive evaluations. Then, once a week until we consistently reach 100% compliance over three consecutive evaluations. Then, one more time a month later, if we are still at 100% compliance we will conclude that we have successfully addressed the deficient practice. The findings will be analyzed in the QA meetings to ensure regulatory compliance.	

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F 657	Continued From page 14	F 657		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of other facility documentation as indicated, it was determined that for two (R78 and R65) out of 43 sampled residents, the facility failed to ensure IDT meetings were held. In addition, the facility failed to ensure that the care plan was developed by an IDT that included the attending physician	F 657	A. R78 and R65 care plans are unable to be retroactively corrected. B. Residents have the potential to be affected. C. E1/NHA and designee will ensure	1/16/19

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F 657	Continued From page 15 and a nurse aide with responsibility for the resident. Findings include: The facility's guideline titled, Care Conference: Interdisciplinary, dated 2016, documented that the Registered Nurse Assessment Coordinator, Social Services, Dietary, Nursing, Activities, Restorative, and Physical Therapy was the core staff for the IDT. In addition, CNA and physician are recommended to attend the care conference. 1. The following was reviewed in R78's clinical record: 3/8/18 - Quarterly MDS assessment. 3/20/18 - IDT Meeting documented staff attendance by E13 (RN, UM), E15 (Activities Director), and E14 (Registered Dietician 1). No attendance by CNA or R78's attending physician. 5/30/18 - Quarterly MDS assessment. Record review lacked an IDT Meeting following the above assessment. 8/23/18 - Quarterly MDS assessment. 9/4/18 - IDT Meeting documented staff attendance by E16 (RN, UM), E15, and E17 (Registered Dietician 2). No attendance by CNA or R78's attending physician. 12/12/18 at 3:22 PM - An interview with E4 (Social Worker) confirmed the facility had no evidence that an IDT meeting was held after the 5/30/18 MDS assessment. E4 verbalized the IDT meeting participants included the Director of Social Services, Unit Manager, Activities Director,	F 657	meeting will be held with the participation of the resident and the resident s representative (s), together with the interdisciplinary team (IDT) to be invited and informed of the resident s schedule for the Comprehensive, Quarterly and Significant Change MDS review assessments. The IDT team includes, the attending physician, registered nurse, nurse aide and member of the food and nutrition services staff, social services, but not limited to all those responsible for the resident or professionals in disciplines as determined by the resident s needs or requested by the resident. E1/NHA and designee will ensure that a care plan will be developed after each IDT meeting and reviewed/revised by the IDT team after each assessment within appropriate time-frame. E2/DON or designee will educate staff on progress notes to include in the resident s medical record. D. NHA/DON/designee will audit IDT care plan meetings to ensure the care plan meetings are being held and care plan was developed by the IDT members that includes the physician and CNA, five days per week until three consecutive 100% compliance is achieved. Then, three times a week until we consistently reach 100% compliance over three consecutive evaluations. Then, once a week until we consistently reach 100% compliance over three consecutive evaluations. Then, one more time a month later, if we are still at 100% compliance we will conclude that we have successfully addressed the deficient practice. The findings will be	

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F 657	Continued From page 16 the Registered Dietician, and a staff from the Therapy Department. E4 confirmed both the CNA and the resident's attending physician was not included as the core IDT, although the CNA was encouraged to attend the meeting to support the resident and that the attending physician was invited as needed. 2. The following was reviewed in R65's clinical record: 1/23/18 - Significant change MDS assessment. Record review lacked an IDT Meeting following the above assessment. 4/18/18 - Quarterly MDS assessment. 5/1/18 - IDT Meeting documented staff attendance by E13 (RN, UM), E15 (Activities Director), and E17 (Registered Dietician 2). No attendance by CNA or R78's attending physician. 7/13/18 - Quarterly MDS assessment. 7/24/18 - IDT Meeting documented staff attendance by E13 (RN, UM), E15, E18 (Rehabilitation Department Staff), and E17. No attendance by CNA or R78's attending physician. 12/13/18 at 12:23 PM - An interview with E4 confirmed the facility had no evidence that an IDT meeting was held after the 1/23/18 assessment . E4 confirmed both the CNA and the resident's attending physician was not included as the core IDT, although the CNA was encouraged to attend the meeting to support the resident and that the attending physician was invited as needed.	F 657	analyzed in the QA meetings to ensure regulatory compliance	

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F 657	Continued From page 17 The above findings were reviewed with E1 (NHA) and E2 (DON) on 12/14/18, during the exit conference starting at 2:15 PM.	F 657		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, interview, and review of other documents as needed, it was determined that the facility failed to ensure that one (R60) out of 43 sampled residents received treatment and services in accordance with professional standards of practice and the comprehensive person-centered care plan. Findings include: The facility policy titled "Pain Assessment", dated 2016, indicated, "...staff is do to a follow up assessment within two hours after administration of medication...and document the resident's response to the pain relief used". The facility policy titled "Change of Condition: Physician", dated 2016, indicated, "A change in a resident's condition will be reported to the physician in a timely manner...Type of conditions that require notification of the physician: ...Change in vital signs..."	F 684	A. R60 unable to retroactively correct. B. DON/designee ran a report for all residents receiving Tylenol/PRN medicine for pain and no other residents have been affected. C. E2 DON/designee will educate the licensed nursing staff on the documentation of PRN pain medication in the EMAR and the documentation of the follow up pain assessment within 2 hours of medication administration. E2 DON/designee will also educate on recognizing vital signs that are considered abnormal and the importance of reassessing abnormal vital signs. E2 DON/designee will also review recognizing change in condition and notifying the MD as soon as the change is recognized.	1/16/19

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F 684	Continued From page 18 The CDC report titled, "High Blood Pressure Fact Sheet", last reviewed 6/16/16, indicated, "A blood pressure less than 120/80 mmHg is normal. A blood pressure of 140/90 mmHg or more is too high." Review of R60's clinical record revealed: 7/30/18 - R60 was admitted to the facility with diagnoses that included hypertension and heart disease. 8/20/18 at 12:01 AM - A progress note documented, R60 "complained of pain all over her body and had an elevated blood pressure of 178/76." It was also documented in the note that R60 was given Tylenol, and the nurse was going to continue to monitor. Review of R60's August eMAR and progress notes lacked evidence that R60 was given Tylenol on 8/20/18, that a follow up pain assessment was done, or that the physician was notified of her elevated blood pressure. 8/20/18 at 10:41 AM - A progress note documented, R60 "complained of not feeling right, had an increase in blurry vision with a slight headache, complained of nausea, and her pain was 4 out of 10 on the pain scale." R60's blood pressure was documented to be 252/120. The physician was paged and R60's blood pressure recheck was 220/100. R60's clinical record lacked evidence that R60's blood pressure was rechecked following the elevated blood pressure at 12:01 AM (a 10 hour gap between assessments).	F 684	D. DON/designee will audit resident s who receive PRN medication to ensure proper EMAR documentation and follow up pain assessment is complete. DON/designee will also audit residents who exhibit high blood pressure to ensure re-assessment was completed timely and communicated to the physician five days per week until three consecutive 100% compliance is achieved. Then, three times a week until we consistently reach 100% compliance over three consecutive evaluations. Then, once a week until we consistently reach 100% compliance over three consecutive evaluations. Then, one more time a month later, if we are still at 100% compliance we will conclude that we have successfully addressed the deficient practice. The findings will be analyzed in the QA meetings to ensure regulatory compliance.	

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F 684	Continued From page 19 8/20/18 at 10:52 AM - A progress note documented, the physician called back and was made aware of R60's history and current blood pressure. A new order was received for Hydralazine 50 mg one time, now. The facility failed to provide evidence that R60 was given pain medication as documented in the progress note and failed to complete a follow up pain assessment. In addition, the facility failed to reassess R60's elevated blood pressure, or notify the physician about the change in condition for 10 hours. Findings were reviewed at the exit conference with E1 (NHA) and E2 (DON) at 2:15 PM.	F 684		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when	F 692		1/16/19

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F 692	Continued From page 20 there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of facility policy, it was determined that the facility failed to recognize, evaluate, and address a significant weight loss for one (R77) out of 43 sampled residents. Findings include: The facility's policy titled, "Weight Policy and Process Guidelines", undated, indicated, "Re-weigh parameters: if there is a five pound or five percent difference in weight (whichever is greater) from the previous weight, a reweigh must be completed within appropriate time frame...Residents with weight variances are re-weighed within 48 hours...The nursing team reports any discrepancies in weight (changes or fluctuations) to the Registered Dietician...A designated Nursing Team Member notifies the attending Physician and Responsible Party regarding any significant weight changes, both losses and gains (5% in 30 days, 7.5% in 90 days, or 10% in 180 days)." Review of R77's clinical record revealed: R77 was admitted to the facility on 10/23/18. Review of R77's care plan revealed that starting on 10/27/18, R77 was at risk for altered nutrition/hydration status. Interventions included weighing R77 per facility policy and consulting the dietician as needed. Review of R77's weights revealed the following: on 10/27/18, R77 weighed 145.2 lbs, on 11/19/18, R77 weighed 140.0 lbs, and on 12/5/18, R77	F 692	A. R77 was immediately assessed by physician and dietitian and care plan was reviewed to address weight loss. B. E2/DON and Registered Dietitian reviewed and reevaluated clinical records for all residents with any weight discrepancies and no other residents have been affected. C. E2 DON/designee will educate licensed staff to re-weigh residents within 48 hours, if there is a five pound or five percent difference in weight (whichever is greater) from the previous weight within appropriate time frame and to assign the Unit Managers to review weights daily. Unit Managers/designee will report any discrepancies in weight (changes or fluctuations) to the Registered Dietician and notifies the attending physician and responsible party regarding any significant weight changes, both losses and gains (5% in 30 days, 7.5% in 90 days, or 10% in 180 days). The designated nursing staff will document in progress notes when Registered Dietitian and physician are notified per facility policy. All nursing staff shall be in-serviced. D. DON/designee will audit resident s who are experiencing weight loss to ensure re-weight was completed and Registered Dietitian and attending physician were notified five days per week	

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F 692	Continued From page 21 weighed 130.0 lbs. From 10/27/18 to 12/5/18 (approximately 6 weeks), R77 had a significant weight loss of 10.47%. Review of R77's clinical record lacked evidence that the physician or registered dietician were notified per facility policy after R77 had a significant weight loss on 12/5/18. In addition, there were no progress notes documented regarding R77's weight loss. R77's clinical record lacked evidence that R77 was weighed within 48 hours per facility policy. The next documented weight for R77 was on 12/12/18 (one week after the R77's first documented significant weight loss on 12/5/18), and she now weighed 131.8 lbs. This was still a significant weight loss of 9.23% from 10/27/18. Review of R77's clinical record lacked evidence that the physician or registered dietician were notified per facility policy after R77 had a significant weight loss on 12/12/18. In addition, there were no progress notes documented regarding R77's weight loss. During an interview on 12/13/18 at 4:30 PM, E17 (Registered Dietician 2) and E2 (DON) stated that with a significant weight loss a re-weigh should be done within 48 hours, and the physician and dietician were to be notified. E2 stated she was not sure why this did not occur and would need to check with nursing. During an interview on 12/14/18 at 10:44 AM, E2 confirmed that there was no documentation acknowledging R77's significant weigh loss prior to the surveyors questioning.	F 692	until three consecutive 100% compliance is achieved. Then, three times a week until we consistently reach 100% compliance over three consecutive evaluations. Then, once a week until we consistently reach 100% compliance over three consecutive evaluations. Then, one more time a month later, if we are still at 100% compliance we will conclude that we have successfully addressed the deficient practice. The findings will be analyzed in the QA meetings to ensure regulatory compliance.	

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F 692	Continued From page 22 The facility failed to recognize, evaluate, and address R77's significant weight loss when she had a significant weight loss of 10.47% in approximately 6 weeks. During the Exit Conference on 12/14/18 at approximately 2:00 PM, findings were reviewed with E1 (NHA) and E2.	F 692		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, it was determined that the facility failed to provide care to respiratory equipment for two (R35 and R65) out of 43 sampled residents. Findings include: 1. 12/11/18 at 10:05 AM - A random observation of R35's oxygen machine, revealed the oxygen filter with an accumulation of dust. 12/11/18 at 10:30 AM - A joint observation with E16 (RN, UM) confirmed that the filter had an accumulation of dust and required cleaning. 2. 12/11/18 at 10:10 AM - A random observation of R65's oxygen machine, revealed the oxygen filter had an accumulation of dust.	F 695	A. R35 and R65 s oxygen filters were immediately replaced. B. No other residents impacted. C. DON/designee will educate staff on providing care to oxygen equipment, including replacement of filters. E2 DON/designee will also educate staff on the weekly cleaning schedule for the oxygen filters with 02 tubing changes. All nursing staff shall be in-serviced. D. DON/designee will audit monitor/verify and inspect respiratory equipment to be free of dust five days per week until three	1/16/19

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F 695	Continued From page 23 12/11/18 at 10:35 AM - A joint observation with E16 confirmed that the filter had an accumulation of dust and the filter required cleaning. The above findings were reviewed with E1 (NHA) and E2 (DON) on 12/14/18, during the exit conference starting at 2:15 PM.	F 695	consecutive 100% compliance is achieved. Then, three times a week until we consistently reach 100% compliance over three consecutive evaluations. Then, once a week until we consistently reach 100% compliance over three consecutive evaluations. Then, one more time a month later, if we are still at 100% compliance we will conclude that we have successfully addressed the deficient practice. The findings will be analyzed in the QA meetings to ensure regulatory compliance.	
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 interview and review of other facility documentation as indicated, it was determined, that the facility failed to ensure performance appraisals were completed at least every 12 months for 4 (E6, E7, E8, and E9) out of 6 sampled CNAs. Findings include: Review of facility documentation revealed: The facility's policy titled, "#301 Performance Evaluation", (undated), indicated, evaluations will be conducted for employees no later than 3 months from the date of hire and annually on their	F 730	A. E8 and E7 no longer work at Regency Healthcare. E9 and E6 performance evaluations will be completed. B. No individual residents or additional employees were impacted. C. E1 NHA/designee will educate staff on timely performance evaluations to be completed at least once every 12 months for every nurse aide. D. Evidence of Compliance: E1	1/16/19

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F 730	Continued From page 24 anniversary date. The facility's job description, for the Director of Nursing Services, dated July 2006, indicated that the purpose of this position was to provide nursing management, set resident care standards for all direct care providers, and to provide complete supervision and management for the nursing department. 1. E9 (CNA) had a date of hire of 1/9/17. Record review revealed a 90 day performance review was conducted on 4/24/17. There was a lack of evidence of an annual performance evaluation. 2. E6 (CNA) had a date of hire of 10/30/17. Record review revealed a 90 day performance review was conducted on 5/17/18. There was a lack of evidence of an annual performance evaluation. 3. E7 (CNA) had a date of hire of 8/7/17. Record review revealed a 90 day performance review was conducted on 4/9/18. There was a lack of evidence of an annual performance evaluation. 4. E8 (CNA) had a date of hire of 10/6/14. Record review revealed the last annual performance was completed on 11/13/17. There was a lack of evidence of a subsequent annual performance evaluation. 12/14/18 at 12:35 PM - The above findings confirmed with E2 (DON). The above findings were reviewed with E1 (NHA) and E2 (DON) on 12/14/18, during the exit conference starting at 2:15 PM.	F 730	NHA/designee will audit and ensure performance appraisals are completed at least once every 12 months for nurse aides. Frequency/Monthly: Success: 100% assessments of annual performance evaluations are completed. Failure: 1 episode will require additional corrective action. The findings will be analyzed in the QA meetings to ensure regulatory compliance.	

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F 732	Continued From page 25	F 732		
F 732 SS=D	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever	F 732		1/16/19

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F 732	Continued From page 26 is greater. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined, that the facility failed to post the nurse staffing data in a prominent place, readily accessible to residents and visitors for 1 out of 2 nursing units. Findings include: 12/11/18 at 9:10 AM - An observation of the 2nd floor nursing station revealed the nursing staffing data, which was posted inside of the nursing station, thus, not located in a prominent place and not accessible to residents and visitors. 12/11/18 at 9:20 AM - An interview with E5 (LPN) revealed, that nurse staff data posting was typically located behind the nursing station. 12/11/18 at 10:43 AM - An interview with E16 (RN, UM) confirmed that the nursing staffing data posting should not be posted inside of the nursing station but rather, outside of the nursing station, where the posting would be accessible to residents and visitors. The above findings were reviewed with E1 (NHA) and E2 (DON) on 12/14/18, during the exit conference starting at 2:15 PM.	F 732	A. All findings identified during survey were corrected immediately by E1/DON and nurse staffing data was relocated and posted in a prominent area accessible and visible to residents and visitors on both units. B. Residents have the potential to be affected and the right to request the daily nursing staffing data at the beginning of each shift upon oral or written request to make available to the public for review at a cost not to exceed the community standard. C. The facility nursing staffing data is visible to residents and visitors within the facility at the nurse s station on each floor/units in clear frames in a readable format. D. DON/designee will audit location of schedule daily until three consecutive 100% compliance is achieved. Then, three times a week until we consistently reach 100% compliance over three consecutive evaluations. Then, once a week until we consistently reach 100% compliance over three consecutive evaluations. Then, one more time a month later, if we are still at 100% compliance we will conclude that we have successfully addressed the deficient practice. Results will be analyzed in the QA meetings to ensure regulatory compliance.	

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F 740 SS=D	Behavioral Health Services CFR(s): 483.40 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health 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. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined, for one (R78) out of one sampled residents, with mood and behavioral issues, the facility failed to provide the necessary behavioral health services to attain the highest practicable mental and psychological well-being. Findings include: Review of R78's clinical record revealed: 11/7/18 - R78 was readmitted to the facility from the hospital. 11/7/18 - Readmission physician's orders included the following: - Trazadone, a medication to treat depression. - Venlafaxine, a medication to treat depression. - Consult psychologist (a non-medical doctor who treats mental disorders) as necessary. - Consult psychiatrist (a medical doctor who treats mental disorders) as necessary. 11/7/18 - The care plan for behavioral health diagnoses including depression, included a goal	F 740	A. R78 was not adversely impacted and behavior monitoring for care plan interventions were provided for resident to attain the highest practicable mental and psychological well-being. B. E2/DON reviewed and reevaluated clinical records for all residents with depressed moods and behavioral issues and no other residents were impacted. C. E2 DON/designee will educate staff on mood and behavioral issues to provide the necessary behavioral health services to attain the highest practicable mental and psychological well-being. E2 DON/designee will also educate nursing staff on monitoring care plan interventions, effectiveness of the medications to treat depression, monitoring of risk to harm self, monitoring risk of harming others and monitoring signs or symptoms of depression. The nursing staff will also conduct a mood	1/16/19

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F 740	Continued From page 28 that R78 will exhibit indicators of depression, anxiety or sad mood less than daily by review date in 90 days. Interventions included: - Administer medications as ordered. - Monitor/document for side effects and effectiveness. - Arrange for psych consult, follow up as indicated. - Discuss with resident, any concerns, fears, issues regarding health or other subjects every shift. - Monitor for risk for harm to self: suicidal plan, past attempt at suicide, risky actions (stockpiling pills, saying goodbye to family, giving away possessions or writing a note), intentionally harmed or tried to harm self, refusing to eat or drink, refusing med or therapies, sense of hopelessness or helplessness, impaired judgment or safety awareness. - Monitor for risk for harming others: increased anger, mood swings or agitation, feels threatened by others or thoughts of harming someone, possession of weapons or objects that could be used as weapons. - Monitor for sign or symptoms of depression, including: hopelessness, anxiety, sadness, verbalizing, negative statements, repetitive anxious or health-related complaints, tearfulness. 11/7/18 through 12/13/18 - Review of R78's clinical records, including the progress notes, Medication Administration Records, Treatment Administration Records, and the CNA records lacked evidence that the facility was monitoring the care planned interventions which included (1) effectiveness of the medications to treat depression (2) monitoring of R78's risk to harm self (3) monitoring R78's risk of harming others, and (4) monitoring of signs or symptoms of	F 740	assessment to be performed on every resident on anti-depressant medication and assessed every shift for depressive mood such as hopelessness to be reported on the behavior monitoring sheet for on the residents MAR. D. DON/designee will audit the behavior assessment of residents who are currently being treated for depression or have depressed mood to ensure monitoring of signs and symptoms of depression is completed five days per week until three consecutive 100% compliance is achieved. Then, three times a week until we consistently reach 100% compliance over three consecutive evaluations. Then, once a week until we consistently reach 100% compliance over three consecutive evaluations. Then, one more time a month later, if we are still at 100% compliance we will conclude that we have successfully addressed the deficient practice. The findings will be analyzed in the QA meetings to ensure regulatory compliance.	

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F 740	Continued From page 29 depression. 11/14/18 - The annual MDS assessment documented that R78 was independent in daily decision making and no evidence of depressed mood. 12/11/18 at 2:30 PM - An interview with R78 revealed she felt depressed and the last time she was evaluated and treated by a psychiatrist was approximately 1 year ago. R78 indicated although she was receiving medications to treat her depressed mood, she continued to feel depressed. 12/13/18 at 11:05 AM - An interview with E2 (DON) revealed monitoring of the depressed mood would be on the eMAR and confirmed when R78 was readmitted to the facility on 11/7/18, the facility failed to ensure care planned interventions to monitor (1) effectiveness of the medications to treat depression (2) monitoring of R78's risk to harm self (3) monitoring R78's risk of harming others, and (4) monitoring of signs or symptoms of depression. The above findings were reviewed with E1 (NHA) and E2 on 12/14/18, during the exit conference starting at 2:15 PM.	F 740		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:	F 758		1/16/19

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F 758	Continued From page 30 (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or	F 758		

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F 758	Continued From page 31 prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure adequate monitoring of anti-psychotic medications for one (R47) out of 43 sampled residents. For R47, the facility failed to do AIMS testing after starting her on an antipsychotic. Findings include: Review of R47's clinical record revealed: R47 was admitted to the facility on 12/9/14 with diagnoses including delusional disorder and dementia with behavioral disturbance. R47 had a physician's order, starting on 7/31/18, to receive Seroquel tablet 25 mg 1 tablet by mouth two times a day for psychosis. Review of R47's care plan revealed that starting on 9/13/18, R47 had the potential for psychotropic drug related side effects related to taking scheduled antipsychotic medication. Interventions included for the facility to provide AIMS testing. On 12/12/18, R47 received a physician's order to increase her Seroquel from two times a day to three times a day. Review of R47's clinical record lacked evidence that an AIMS test was completed after R47 started on an antipsychotic (Seroquel) on 7/31/18. During an interview on 12/13/18 at 2:22 PM, E3 (RN Unit Manager) confirmed that an AIMS test was never completed after R47 began taking	F 758	A. R47 AIMS test was completed on 12/18/18 and was not adversely affected by the antipsychotic medication. B. No other resident s were impacted. C. E2 DON/designee will educate licensed nursing staff on adequate monitoring of anti-psychotic medications and in-services on AIMS testing after residents begin psychotropic drugs based on a comprehensive assessment of a resident to ensure that residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record. Licensed nursing staff will also be in-serviced on residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs as well as education on residents on PRN orders for psychotropic drugs that are limited to 14 days, as appropriate for the PRN order to document rationale in the residents medical record and indicate the duration for the PRN order. D. DON/designee will audit residents who are on anti-psychotics to ensure completion of a baseline AIMS assessment upon starting an antipsychotic five days a week until three	

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F 758	Continued From page 32 Seroquel. E3 stated that at the facility, they do AIMS testing every 6 months, and R47 should have received an initial assessment. During the Exit Conference on 12/14/18 at approximately 2:00 PM, findings were reviewed with E1 (NHA) and E2 (DON).	F 758	consecutive 100% compliance is achieved. Then, three times a week until we consistently reach 100% compliance over three consecutive evaluations. Then, once a week until we consistently reach 100% compliance over. The findings will be analyzed in the QA meetings to ensure regulatory compliance.	
F 808 SS=D	Therapeutic Diet Prescribed by Physician CFR(s): 483.60(e)(1)(2) §483.60(e) Therapeutic Diets §483.60(e)(1) Therapeutic diets must be prescribed by the attending physician. §483.60(e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that for one (R78) out of 43 sampled residents the facility failed to ensure liquids were thickened, as ordered by the physician. Findings include: Review of R78's clinical record revealed: 12/7/18 - A physician's order for nectar thickened liquids during meals due to swallowing difficulty. 12/11/18 at 12:23 PM - During a meal observation, E12 (CNA) offered R78, a bowl of chicken noodle soup and shortly after consuming the soup, R78 began to cough. Immediately, the surveyor notified E5 (LPN) of the above	F 808	A. R78 was not adversely impacted by the thin liquids given. R78 was reassessed and monitored since occurrence by licensed nurse and speech therapist and prescribed a diet by the physician with proper liquid consistency. B. No other residents were impacted. C. Nursing staff will be in-serviced to ensure liquids are thickened per order by physician during meals. D. DON/designee will audit residents who are ordered thicken liquids to ensure proper fluid consistencies are provided to	1/16/19

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F 808	Continued From page 33 observation. E5 immediately interceded and proceeded to thicken the broth of the soup with a nectar thickener powder. E5 confirmed that the broth of the soup should have been thickened to the nectar thickened consistency prior to providing the soup to R78. The above findings were reviewed with E1 (NHA) and E2 (DON) on 12/14/18, during the exit conference starting at 2:15 PM.	F 808	the resident with each meal, five days a week until three consecutive 100% compliance is achieved. Then, three times a week until we consistently reach 100% compliance over three consecutive evaluations. Then, once a week until we consistently reach 100% compliance over three consecutive evaluations. Then, one more time a month later, if we are still at 100% compliance we will conclude that we have successfully addressed the deficient practice. Results will be analyzed in the QA meetings to ensure regulatory compliance.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following	F 880		1/16/19

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F 880	Continued From page 34 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. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 880		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 35 §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility documentation, it was determined that for 1 (R87) out of 2 residents reviewed for pressure ulcers, the facility failed to ensure proper infection control practices and handwashing during a wound dressing change. During medication pass observation contaminated medical equipment was not cleaned after use. Findings include: The facility policy, titled, "Treatment Administration Technique and Documentation" (undated), indicated to wash hands prior to and after treatment The facility policy for Hand washing / Hand Hygiene (revised August 2015), documented hand washing indications included: -before handling clean or soiled dressing; gauze pads, etc.; -after handling used dressings, contaminated equipment, etc.; -after contact with objects (e.g., medical equipment) in the immediate vicinity of the resident; -after removing gloves; Procedure was to vigorously lather hands with soap and rub them together, creating friction to all surfaces, for a minimum of 20 seconds (or longer) under a moderate stream of running water, at a comfortable temperature... 1. Wound Observation: 12/13/18 2:35 PM - Observation of E20 (LPN)	F 880	1. A. R87 was not adversely impacted by E20 s hand hygiene procedure during wound treatment. E20 has been educated on proper hand washing techniques. B. Residents have the potential to be affected. C. E2 DON/designee will educate nursing staff and CNAs to ensure proper infection prevention and control programs such as handwashing prior to and after treatment of care and review the facility policy designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. E20 was immediately re-educated on facility policy for Hand washing/Hand Hygiene on procedure to lather hands with soap and rub them together, creating friction to all surfaces, for a minimum of 20 seconds (or longer) under a moderate stream of running water, at a comfortable temperature. D. DON/designee will audit residents who are ordered treatments to ensure staff is performing proper hand washing procedure during treatment and will rotate observations between each shift, five	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085012	A. BUILDING _____ B. WING _____	12/14/2018

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F 880	Continued From page 36 performing a treatment to R87's buttocks area E20 washed hands upon entering the room. E20 then proceeded to touch the over the bed table and use the bed remote to raise the bed contaminating her hands. E20 changed gloves without performing hand hygiene and proceeded to open supplies, remove old dressing and clean the wound. After cleaning the wound E20 removed gloves and did hand washing for 3-5 seconds donning new gloves. The treatment was completed and supplies cleaned up. Before leaving the room E20 performed hand washing for 2-3 seconds. 2. Medication Pass Observation: 12/12/18 9:47 AM to 10:13 AM - During medications pass observation with E19 (RN), the nurse laid the stethoscope on the bed touching sheet and blanket. E19 then used the stethoscope to listen to stomach sounds before doing medication through a tube to the stomach. Before leaving the room s/he picked up stethoscope and put it back on around the neck. After leaving the room s/he went to medication cart, to the utility room and back to the cart. E19 was not seen cleaning the stethoscope before placing it around her neck or after she left the resident's room. The above findings were reviewed with E1 (NHA) and E2 (DON) on 12/14/18, during the exit conference starting at 2:15 PM.	F 880	times a week until three consecutive 100% compliance is achieved. Then, three times a week until we consistently reach 100% compliance over three consecutive evaluations. Then, once a week until we consistently reach 100% compliance over three consecutive evaluations. Then, one more time a month later, if we are still at 100% compliance we will conclude that we have successfully addressed the deficient practice. Results will be analyzed in the QA meetings to ensure regulatory compliance. 2. A. E19 was immediately in-serviced on infection control measures relating to medical equipment during medication pass. B. Residents requiring assessment with stethoscope/medical equipment have the potential to be affected. C. Nursing staff will be educated on infection prevention and control programs relating to standard and transmission-based precautions to be followed to prevent spread of infection prior to and after medical equipment use (such as stethoscope) and review facility policy for Hand washing/Hand Hygiene. D. DON/designee will audit residents who require peg tub medication passes and will rotate observations between each shift to ensure the staff use proper infection	

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F 880	Continued From page 37	F 880	control process when cleaning their stethoscope after use, five days a week until three consecutive 100% compliance is achieved. Then, three times a week until we consistently reach 100% compliance over three consecutive evaluations. Then, once a week until we consistently reach 100% compliance over three consecutive evaluations. Then, one more time a month later, if we are still at 100% compliance we will conclude that we have successfully addressed the deficient practice. Results will be analyzed in the QA meetings to ensure regulatory compliance.	

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

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

STATE SURVEY REPORT

NAME OF FACILITY: Regency Healthcare & Rehabilitation DATE SURVEY COMPLETED: December 14, 2018

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 annual survey was conducted at this facility from December 11, 2018 through December 14, 2018. The deficiencies contained in this report are based on the observations, interviews, review of clinical records, and other facility documentation as indicated. The facility census the first day of the survey was 92. The survey sample size was 43.	**Please cross refer to our Plan of Correction the CMS 2567 Annual survey date 12/14/18, submitted on 1/6/19.**	2/14/19
3201	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.0	**Scope**		
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. 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 the following:** Cross Refer to the CMS 2567-L survey completed December 14, 2018: F550, F558, F561, F656, F657, F684, F692, F695, F730, F732, F740, F758, F808, and F880.		

Provider's Signature _____ Title NHA Date 12/27/18

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Provider's Signature _____ Title NHA Date 12/27/18