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

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

STATE SURVEY REPORT

NAME OF FACILITY: Millcroft Nursing Home

DATE SURVEY COMPLETED: September 15, 2020

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 by the State of Delaware Division of Health Care Quality, Office of Long Term Care Residents Protection from September 4, 2020 through September 15, 2020. The facility was found to be out of compliance with the Title 16 Health and Safety Delaware Administrative Code and 3225 Skilled Nursing Facilities regulations. The facility census was fifty-one (51). The sample size was six (6).		
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 was not met as evidenced by:**	Cross reference 2567-L dated 11/12/2020, for response to: F561, F585,F657,F695 and F725.	12/15/2020

Provider's Signature William Peterson Title Interim Exec. Dir. Date 11/12/20

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	Cross Refer to the CMS 2567-L survey completed September 15, 2020: F561, F585, F657, F695 and F725.		

Provider's Signature _____ Title _____ Date _____

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
	085021	A. BUILDING _____ B. WING _____	C 09/15/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLCROFT	255 POSSUM PARK ROAD NEWARK, DE 19711

(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 by the State of Delaware Division of Health Care Quality, Office of Long Term Care Residents Protection from September 4, 2020 through September 15, 2020. The facility was found to be out of compliance with the Title 16 Health and Safety Delaware Administrative Code and 3225 Skilled Nursing Facilities regulations. The facility census was fifty-one (51). The sample size was six (6). Abbreviations/definitions used in this report are as follows: ADLs (activities of daily living) - tasks needed for daily living, for example, dressing, hygiene, eating, toileting, and bathing; ADON - Assistant Director of Nursing; CNA - Certified Nurse's Aide; DON - Director of Nursing; EMR - Electronic Medical Record; eMAR- Electronic Medication Administration Record; F - Fahrenheit; FMD - Facility Maintenance Director; gm - gram (30 grams = 1 ounce); ICP - Infection Control Preventionist; LPN - Licensed Practical Nurse; mcg - micrograms; MDS - Minimum Data Set/assessment tool used in long term care; mg - milligram; MRR - Monthly Regimen Review; NHA - Nursing Home Administrator; RN - Registered Nurse; SW - Social Worker; TAR - Treatment Administration Record; UM - Unit Manager;	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: William Peterson
TITLE: Interim Exec. Director
(X6) DATE: 11/2/20

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

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F 000	Continued From page 1 > - greater than.	F 000		
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 by: Based on record review, review of other facility documentation, observation and interview, it was determined that for three (R1, R2 and R3) out of six sampled residents reviewed for activities, the	F 561	F561 A. Residents R1, R2 and R3 were not adversely affected by this deficient practice. R1 plan of care revised, is able to go outside for fresh air while following covid guidelines. R2 plan of care revised, is able to go outside for fresh air while following covid guidelines. R3 plan of care revised, is able to go outside for fresh air while following covid guidelines. B. All residents have the potential to be affected by this alleged deficient practice. C. The root cause analysis has identified the facility did not have scheduled outdoor activities for the residents due to the current covid pandemic. In addition, the staff misinterpretation of the covid guidance that the residents were "safer" by remaining in their rooms. All residents have been informed that they can request to go outside. Staff Development Coordinator or designee to educate the Healthcare staff on the right of the resident to request and go outside for fresh air.	12/15/2020

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F 561	Continued From page 2 facility failed to evaluate their practices of maintaining the residents' safety while facilitating self-determination by supporting resident choice to go outside and enjoy the fresh air as changes occurred in the facility during the COVID-19 pandemic. Findings include: 3/13/2020 at 8 AM - The Governor of the State of Delaware declared a State of Emergency due to a Public Health Threat from COVID-19. 9/7/2020 - The infection control line list since the beginning of the pandemic revealed that COVID-19 positive cases occurred in the facility during the months of May 2020, first half of June 2020 and the first half of July 2020. cross refer to F585 1. R1's clinical record review, observations and interviews revealed: 2/13/2020 - R1 was admitted to the facility. 8/6/2020 - A grievance was filed on behalf of R1 for two issues, with one issue for R1 "being allowed to get fresh air." 8/7/2020 - In response to the 8/6/2020 grievance for "fresh air", E4 (SW) wrote, " ... The plan of implementing sunshine (outside) visitation with staff support was explained as this will allow the resident (R1) to continue getting fresh air outside, combined with a nice visit from family ...". 8/7/2020 at 12:14 PM - A health status note included, "Weekly update given on COVID status to RP and to resident. Facility is currently COVID free. Everyone is happy. All questions and	F 561	D. A random audit of 10% of AAOX3 residents to be completed by ED or designee weekly X4 to verify "sunshine visits" are scheduled and residents are offered to go outside for fresh air until 100% success is achieved; monthly X 2 months until 100% success is achieved. Results of the audits will be submitted to the QAPI committee. The QAPI committee will determine the need for further submissions.	

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F 561	Continued From page 3 concerns addressed." 8/17/2020 - A physician's order stated that R1 is capable of understanding her rights. 8/18/2020 - A physician's order stated that R1 was independent with the Jazzy (electric) scooter during the daytime per an Occupational Therapy clarification. 8/21/2020 (last reviewed) - R1's activity care plan stated that R1 preferred independent activities such as listening to books on tape and visits with family via telephone. One of R1's activity interests was sitting outdoors. R1's care plan stated that during the group restrictions, R1 enjoyed pampered hands, doorway bingo, traveling bingo shop and 1:1 activities provided by staff. R1's care plan goal, dated 8/21/2020, stated that R1 "will maintain involvement in inroom activity such as reading (listening to books on tape) and attending structured doorway held programming as desired through the review date (target date 11/29/2020) due to restrictions on group programming due to the COVID-19 pandemic." The care plan goal and approaches lacked evidence of addressing R1's interest in sitting outdoors. 8/23/2020 at 7:37 PM - R1's brief interview for mental status evaluation assessed that R1 was cognitively intact. 9/4/2020 at 12:07 PM - During an interview, R1 stated, "I feel like a prisoner. I could understand it (staying in your room) very well in the beginning of the pandemic." R1 hasn't been out of her room except for showers and a visit to the hospital where she looked at 4 different walls and a	F 561		

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F 561	Continued From page 4 ceiling. R1 stated that today, 9/4/2020, she was looking forward to her first outside family visit. R1 stated that she was aware of the COVID-19 precautions that she would have to follow: wearing a mask and gloves, maintaining six feet social distance, no food/drink. R1 stated that now the facility was virus free, she "felt like she was missing the summer" as she enjoyed the "scenery and the sounds. Why can't I go outside and sit as I have an electric wheelchair? I am getting cabin fever - I can't go out of the room." R1 stated as an example that after she would fill out her menu choices for the week, she would put her mask on and drive her scooter to the nurses station to drop them off, where an (unidentified) staff person told her "I will take it and go back to your room." R1 stated that she had been at the facility for a previous stay when she was free to sit outside and listen to her books on tape. 9/4/2020 at approximately 4:30 PM - An observation revealed that R1 was wearing a face mask and gloves, and independently operating her scooter from her room accompanied by E3 (Activity Director) and into the elevator on the 2nd floor. Further observation during the outside family visit on the 1st floor patio revealed that R1 followed the COVID-19 precautions. 9/4/2020 at 5:29 PM - An activity note documented that R1 had an outside visit with a family member. R1 maintained social distancing and "had no challenges keeping her mask in place for the entire visit." 9/9/2020 at 2:51 PM - During an interview, the surveyor asked if E4 (SW) interviewed R1 regarding the 8/6/2020 grievance of "being allowed to get fresh air" as the grievance lacked	F 561		

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F 561	Continued From page 5 evidence of this discussion. E4 provided a typed statement, dated 9/9/2020, of the resident interview. E4 stated, " ... The resident (R1) stated that she looked forward to a time when she would be able to go outside for fresh air on her own. Social Services expressed that we are still having all resident's (sic) remain inside the building and their rooms for safety during the current quarantine. Updates to the current plans and policies would be shared with the resident upon their implementation." 2. R2's clinical record review and interview revealed: 6/16/2020 (last reviewed) - R2's activity care plan stated that R2 ambulated independently with a walker. One activity interest included being outdoors. The care plan stated, "During Covid 19 temporary restrictions, engages in inroom activity as she chooses." The care plan goal was that R1 "will engage in independent activities and attend group activities when Covid 19 restrictions are lifted as chooses through target date (11/24/2020)." R2's approaches included: "modify daily schedule, treatment plan PRN to accommodate activity participation as requested by the resident." The activities care plan goal lacked evidence of addressing R2's interest of being outdoors. 6/17/2020 - R2's quarterly MDS assessment stated that she was cognitively intact and ambulated independently. 9/9/2020 at 11:30 AM - During an interview, R2 stated that she used to go outside routinely, but a directive was given and she didn't know by who, that no one could go outside. R2 stated she	F 561		

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F 561	Continued From page 6 would like to go outside and sit even if it was for a specific time period. R2 added that she is aware of the COVID-19 precautions. 3. R3's clinical record review and interview revealed: 3/14/2020 - A physician order stated that R3 was capable of understanding her rights. 4/8/2020 (last reviewed) - R3's activity care plan stated that R3 used a motorized wheelchair independently for mobility. Activity interests included sitting outdoors. The care plan goal stated R3, "will engage in self-directed activities and attend 1:1 activities/door way programming during the Covid 19 pandemic (target date: 10/12/2020)." R3's approaches included: "modify daily schedule, treatment plan PRN to accommodate activity participation as requested by the resident ... provide a program of activities that is of interest and empowers the resident by encouraging/allowing choice, self-expression and responsibility...". The activities care plan lacked evidence of addressing R3's interest in sitting outdoors. 7/6/2020 - R3's quarterly MDS assessment assessed R3 as being cognitively intact. 9/9/2020 at 1:30 PM - During an interview, R3 stated that we (the residents) were told by (unidentified) facility staff person that we could not come out of our rooms. R3 stated that she used to go outside by herself driving her electric wheelchair, but she was told they could not go outside. When asked if activities had offered to take R3 outside, R3 stated no. R3 stated she was aware of the COVID-19 precautions.	F 561		

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F 561	Continued From page 7 9/9/2020 at 1:46 PM - During an interview, E5 (CNA) stated that staff were told to remind residents to stay in their rooms due to the virus (COVID-19). E5 stated that the alert (and oriented) residents are aware of the precautions and accepted them; however, the residents with dementia needed reminders. 9/9/2020 at 2:15 PM - During an interview, E4 (SW) stated that facility staff were following a corporate policy, State directive and CDC/CMS guidelines when telling residents to stay in their rooms for safety, except for medical appointments and therapy services. When the surveyor asked E4 for copies of the corporate policy, State directive and CDC/CMS guidelines directing residents to remain in their rooms, E4 denied having copies and deferred to the facility's management. 9/9/2020 at 3:53 PM - During an interview, E3 (Activity Director) stated that activity staff were told not to take residents out of their rooms and that residents could participate in activities in their doorways or individualized 1:1 in their rooms. 9/10/2020 at 2:15 PM - During an interview, E4 (SW) confirmed that staff were told to keep residents in their rooms. 9/10/2020 at 4:55 PM- During an interview, E2 (Interim DON) confirmed that the facility did not have a corporate policy, nor did they have any supporting evidence through a State directive and CMS/CDC guidelines, that stated to keep residents in their rooms during the entire pandemic.	F 561		

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F 561	Continued From page 8 9/15/2020 at 4 PM - Findings were reviewed during the exit conference with E1 (interim NHA/RCO), E2 (interim DON) and E6 (Staff Educator/Infection Control Preventionist). The facility failed to evaluate their practices of maintaining the residents' safety while facilitating self-determination by supporting resident choice to go outside and enjoy the fresh air as changes occurred in the facility during the COVID-19 pandemic.	F 561		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the	F 585	F585 A. Residents R1 was not adversely affected by this practice. R1 plan of care revised, is able to go outside for fresh air while following covid guidelines. B. All residents have the potential to be affected by this alleged deficient practice. C. The root cause analysis has been performed. The Social Services Director inadvertently missed addressing the second part of the grievance filed. Staff Development Coordinator or designee to educate the Social Services Director or designee on verifying that all aspects of a grievance are addressed. Grievances will be discussed and reviewed daily, Monday through Friday, during morning meeting by the IDT team.	12/15/2020

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F 585	Continued From page 9 provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source,	F 585	D. An audit of grievances to be completed by ED or designee weekly X4 to verify grievances are addressed and resolved per community policy until 100% compliance is achieved; monthly X2 until 100% compliance is achieved. Results of the audits will be submitted to the QAPI committee X3. The QAPI committee will determine the need for further submissions.	

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F 585	Continued From page 10 and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on record review, review of other facility documentation and interview, it was determined that for one (R1) out of three sampled residents for grievances, the facility failed to make prompt efforts to resolve grievances. Findings include: 8/5/2020 - The facility's grievance log documented that F1 (family member) on behalf of R1 filed a grievance for two issues: the resident being allowed to get fresh air and family visitation.	F 585		

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F 585	Continued From page 11 8/7/2020 - A handwritten statement by E4 (SW) stated, "Resident and her family/POA have been made aware of current steps being taken in the process of trying to reestablish normal visitation. The plan of implementing sunshine visitation with staff support was explained as this will allow the resident to continue getting fresh air outside, combined with a nice visit from family ...". 8/8/2020 - The facility's resolution/action plan stated, "[Name of two nursing facilities including the one where R1 resided] management are currently working towards the safest and most ethical way to re-open visitation for healthcare residents. [Name of facility] management / supervisor will be stopping by to see the resident to ensure her well-being is positive on a daily basis. This will also serve to keep the resident informed of progress towards Sunshine Visitation." Despite the facility's resolution / action plan discussing Sunshine Visitation, the facility failed to directly address the second grievance issue: R1 "being allowed to get fresh air" outside of family visitation. 9/4/2020 at 4:30 PM - An observation revealed that R1 had her first outside Sunshine Visit with F2 (family member). This was the first time R1 was outside of the facility and her room since the grievance was filed with the facility on 8/5/2020. 9/9/2020 at 2:51 PM - During an interview, the surveyor asked if E4 (SW) interviewed R1 regarding the 8/5/2020 grievance of "being allowed to get fresh air" as the grievance lacked evidence of this discussion. E4 provided a typed statement (dated 9/9/2020) of the resident interview. E4 stated, " ... The resident (R1) stated that she looked forward to a time when she would	F 585		

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F 585	Continued From page 12 be able to go outside for fresh air on her own. Social Services expressed that we are still having all resident's (sic) remain inside the building and their rooms for safety during the current quarantine. Updates to the current plans and policies would be shared with the resident upon their implementation." 9/15/2020 at 4 PM - Finding was reviewed during the exit conference with E1 (interim NHA/RCO), E2 (interim DON) and E3 (Staff Educator/Infection Control Preventionist). The facility failed to promptly resolve one of the two concerns included in the 8/5/2020 grievance, allowing R1 to get fresh air.	F 585		
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 657	F657 A. Residents R1 continues to reside at the facility and was not adversely affected by this alleged deficient practice. B. All residents have the potential to be affected by this deficient practice. C. The root cause analysis has been performed. The Social Services Director was under the assumption that the family must be present for a care plan meeting to occur. Unable to complete care conference due to the time being in the past. R1's care conferences are currently in compliance as of 9/15/20. In addition, nursing did not realize the need to update the care plan with the new oxygen order.	12/15/2020

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F 657	Continued From page 13 (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 record review and interview it was determined that for two (R1 and R3) out of three sampled residents for care plans/meetings, the facility failed to ensure the required care plan meetings occurred. For R1, the facility also failed to revise the residents' care plan for use of portable oxygen tanks during the night to meet R1's oxygen needs. Findings include: 1. R3's clinical record revealed: 1/23/2020 at 3:15 PM - A social services note documented that a care plan meeting was held with the resident, family member and facility staff. Review of R3's clinical record lacked evidence that a quarterly care plan meeting was held in April 2020. cross refer to F695 2. R1's clinical record revealed: a. 3/11/2020 - A care plan meeting was held with the resident, R1's family and facility staff. Review of R1's clinical record lacked evidence that a quarterly care plan meeting was held with R1 participating from 3/11/2020 to 9/15/2020.	F 657	Staff Development Coordinator or designee to educate the Social Services Director on the care planning process. Nursing will be in-serviced on the need to update the care plan with each new physicians order. D. ED/designee will complete a random audit of residents who are scheduled for a care plan meeting have the opportunity to participate in the review and revision of their care plan. The audits will be done weekly X4 until 100% compliance is achieved; monthly X2 until 100% compliance is achieved. Results of the audits will be submitted to the QAPI committee monthly. The QAPI committee will determine the need for further submissions. DON/designee will complete a random audit of residents with a physician's order to receive oxygen will be audited to verify their care plan has been updated accordingly weekly X4 until 100% compliance is achieved; monthly X2 until 100% compliance is achieved. Results of the audits will be submitted to the QAPI committee monthly. The QAPI committee will determine the need for further submissions.	

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F 657	Continued From page 14 9/9/2020 at 2:15 PM - During an interview, E4 (SW) confirmed that a care plan meeting was not held with R1's participation since 3/11/2020 (approximately six months). b. 2/6/2020 (last revised) - R1's COPD care plan and altered respiratory pattern care plan (dated 3/17/2020) lacked evidence of approaches for R1's need to use portable oxygen tanks continuously during the night. 3/17/2020 (last revised) - R1's care plan for altered respiratory pattern lacked evidence of approaches for her increased oxygen needs using portable oxygen tanks continuously during the night. 8/17/2020 - A physician's order included, "Oxygen at 2 liters via nasal cannula every shift ...may titrate to maintain oxygen saturation above 93%." 8/19/2020 - R1's quarterly MDS assessment was completed. R1's care plan was not updated to reflect R1's current oxygen needs. 9/15/2020 at 4 PM - Findings were reviewed during the exit conference with E1 (interim NHA/RCO), E2 (interim DON) and E3 (Staff Educator/Infection Control Preventionist). The facility failed to ensure that required care plan meetings were held quarterly with the resident and failed to revise R1's care plans to reflect the need for increased portable oxygen tank usage continuously during the night.	F 657		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including	F 695		

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F 695	Continued From page 15 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 record review and interview it was determined that for one (R1) out of three sampled residents reviewed for respiratory care, the facility failed to ensure that R1 received respiratory care for oxygen consistent with professional standards of practice, including that nursing notes included care issues, nursing observations and interventions related to an episode of shortness of breath (SOB). Findings include: cross refer to F657, example #2 8/23/2020 at 7:37 PM - R1's brief interview for mental status evaluation assessed R1 as cognitively intact. 9/5/2020 at 2:47 AM - A nurse's note, written by E6 (LPN), documented that R1's pulse ox was 95% as of 1:28 AM and R1 was receiving oxygen via nasal cannula. The note also stated, " ...Resident continues with Q shift monitoring. Resident is currently sleeping and stable. No s/s or complaints of ... SOB ... noted on this shift. Respirations appears (sic) even and unlabored ...Staff continues to monitor for changes. All needs are met on this shift ...2 L O2 is effective ...". 9/10/2020 at 2:15 PM - During an interview, R1	F 695	F695 A. Residents R1 continues to reside at the facility and was not adversely affected by this deficient practice. R1 plan of care was revised and R1 was switched to a more viable means of oxygen therapy in the overnight hours (uses a concentrator). B. All residents have the potential to be affected by this alleged deficient practice. C. The root cause analysis has been performed. The nurse who responded to the residents call bell failed to document her shortness of breath, assessment and interventions. This was an oversight on the nurses part. Staff Development Coordinator or designee will educate all staff on alerting licensed nursing staff of any changes in a resident's respiratory status. Staff Development Coordinator or designee will also educate licensed nursing staff on how to complete a through respiratory evaluation that includes, observations, evaluations, interventions, notification to resident representative and MD. The education to the licensed nursing staff will also include the necessary documentation to reflect the respiratory change; such as writing a progress note and updating the care plan. D. A daily audit to be completed by Unit Manager or designee to	12/15/2020

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F 695	Continued From page 16 stated that around 5 AM on 9/5/2020, she woke up SOB and used the call bell. R1 stated that when the CNA responded to the call bell, she told the CNA that she wasn't getting any oxygen and would you please ask the nurse to come in. R1 stated that the nurse (E6) came in and stated, "no wonder, who turned it off?" R1 stated that the nurse (E6) turned the tank back on and said there was still some oxygen left. The nurse checked her pulse ox. R1 stated that E6 told her that she will keep her eye on it (the portable oxygen tank). 9/15/2020 at 3:49 PM - During an interview, E6 (LPN) confirmed that R1 used her call bell, the CNA responded first and then she was asked to respond to R1 being SOB. E6 stated that she checked R1's pulse ox and the portable oxygen tank, which she stated was still running (not turned off) and the gauge was still in the yellow range (warning alert to the caregiver that the oxygen level in the tank was almost empty). E6 stated that she repositioned R1 and changed the portable oxygen tank at that time. Despite E6 confirming that R1 used the call bell for a complaint of being SOB, E6 failed to record this event in a nursing note by documenting R1's pulse ox and respirations at the time of R1's complaint, E6's observations and what interventions E6 put into place in response (repositioning R1 and changing the portable oxygen tank) to R1's complaint. Review of R1's clinical record found no evidence regarding R1's 9/5/2020 (around 5 AM) SOB, nor nursing assessment and interventions. 9/15/2020 at 4 PM - Finding was reviewed with E1 (interim NHA/RCO), E2 (interim DON) and E3 (Staff Educator / ICP). The facility failed to ensure	F 695	ensure progress notes are reviewed with proper documentation in place in the event any significant changes have occurred. The audits will be done daily for 2 weeks, weekly for 2 weeks and then monthly for 2 months until 100% compliance is achieved. Results of the audits will be submitted to the QAPI committee. The QAPI committee will determine the need for further submissions.	

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F 695	Continued From page 17 that R1's episode of SOB and any nursing assessment and interventions were reflected in the clinical record for this change in respiratory status / significant event.	F 695		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on record review, review of other facility documentation and interview, it was determined	F 725	F725 A. R1 was not negatively impacted by this alleged deficient practice. B. All residents are at risk for this alleged deficient practice. C. The root cause analysis revealed that on multiple occasions, the staff who answer the call bell forget to turn it off while performing care. Additionally, not all staff were answering the call bells i.e. non-nursing staff. Staff Educator/designee will educate all staff who work on the Healthcare Unit on the need to answer a call bell when one is on. Appropriate personnel will be enlisted to ensure personal care needs are met. D. A daily audit to be completed by Unit Manager/designee to verify call bells are being answered by all staff. The audits will be done daily for 2 weeks, weekly for 2 weeks and then monthly for 2 months until 100% success is achieved. Results of the audits will be submitted to the QAPI committee. The QAPI committee will determine the need for further submissions.	12/15/2020

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F 725	Continued From page 18 that for two (R1 and R3) out of three sampled residents reviewed for ADLs, the facility failed to have sufficient nursing staff to attain or maintain the highest practicable well-being of each resident. Findings include: The corporate policy, effective date 9/1/18, entitled "Answering Call Lights", stated, "This document sets forth procedures to be followed providing an environment that promptly helps meet residents' needs ... III. Procedures. 1. Respond to call lights activated by residents in a timely manner ...4. Turn off the call light in the room so that others will know it is answered ...". While the facility's corporate policy stated to respond to call lights in a "timely manner", it was unclear what "timely manner" meant to facility staff as opposed to the residents and their needs. 1. Review of R1's clinical record, facility documentation and interview revealed: 2/13/2020 - R1 was care planned for limitation(s) in her ability to perform ADLs related to a left above the knee amputation. The resident required assistance of 1 staff person for toileting. 8/23/2020 at 7:37 PM - R1's brief interview for mental status evaluation stated that she was cognitively intact. A recent three week sampling of the facility's Device Activity Report for call bell response times for R1 revealed the following from 8/18/2020 through 9/7/2020: 17 to 19 minutes: 3; 20 to 25 minutes: 5; > 26 minutes: 4.	F 725		

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F 725	Continued From page 19 9/10/2020 at 2:25 PM - During an interview, R1 stated that the call bell wait times are "terrible." R1 stated that "sometimes I can't wait and I self-transfer to the toilet" or "I may have an accident waiting for a response from staff and I feel humiliated that I could not control it." 2. Review of R3's clinical record, facility documentation and interview revealed: 12/3/19 (last revised) - R3 was care planned for limitations in her ability to perform ADLs with approaches that R3 required 2 staff for bed mobility every 2 hours while in bed and 2 staff assistance for Hoyer lift transfers. 7/6/2020 - R3's quarterly MDS assessment stated that she was cognitively intact. A recent three week sampling of the facility's Device Activity Report for call bell waiting times for R3 revealed the following from 8/18/2020 through 9/7/2020: 17 - 19 minutes: 6; 20 - 25 minutes: 9; > 26 minutes: 8. 9/9/2020 at 1:25 PM - During an interview, R3 stated that the call bell response times are too long and that the facility does not have enough staff. 9/15/2020 at 4 PM - During the exit conference, E1 (interim NHA/RCO) and E3 (Staff Educator/Infection Control Preventionist) suggested that some residents require two staff for bed mobility, toileting and/or Hoyer lift	F 725		

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F 725	Continued From page 20 transfers, which may account for the call bell response times if two staff are busy with one resident. In addition, the facility staff may go into a resident's room and forget to turn the call bell off. The surveyor acknowledged that forgetting to turn the call bell off could occur; however, the facility's reasoning cannot explain in a sampling of three weeks why two cognitively intact residents repeatedly had to wait for long periods of time (from 17 to 39 minutes) for their call bells to be answered, when according to corporate policy, call bells were to be answered "in a timely manner" by staff and "in an environment that promptly helps meet the residents' needs." 9/18/2020 at 5:13 PM - During a follow-up question regarding what "respond in a timely manner" means in the facility's call bell policy, E2 (interim DON) stated that she was informed that it means "as quickly as the staff are able to answer the call."	F 725		