STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085051	A. BUILDING _____ B. WING _____	C 01/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELAWARE VETERANS HOME	100 DELAWARE VETERAN'S DRIVE MILFORD, DE 19963

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E 000	Initial Comments An unannounced annual and complaint survey was conducted at this facility from Janurary 15, 2019 through January 23, 2019. The facility census the first day of the survey was 67 (sixty-seven). 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 and complaint visit survey was conducted at this facility from January 15, 2019 through January 23, 2019. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census the first day of the survey was 67. The investigated sample size was 36. Abbreviations and Definitions used in this report are as follows: NHA - Nursing Home Administrator; DON - Director of Nursing; ADON - Assistant Director of Nursing; RN - Registered Nurse; LPN - Licensed Practical Nurse; MD - Medical Doctor; NP - Nurse Practitioner; RNAC - Registered Nurse Assessment Coordinator; CNA - Certified Nurse's Aide; SW - Social Worker; QA - Quality Assurance; UM - Unit Manager;	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/26/2019

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 CNA flow sheet - a form that details care to be provided for each specific resident assigned; ADL'S - Activities of daily living- task needed for daily living , such as dressing, hygiene, eating, toileting, bathing; EHR - Electronic Health Record; EMR - electronic medication record; eMar - electronic medication administration record; IPCP-infection prevention and control program; MDS - Minimum Data Set; standardized assessment forms used in nursing homes; OOB - Out of Bed; OSS - Operation Support Specialist; POA - Power of Attorney; PRN - as needed; Clostridium-difficile - bacterial overgrow that releases toxins that attack the lining of the intestines; Dementia - chronic disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning; Depressive Disorder - also known as depression, is a mental disorder characterized by at least two weeks of low mood that is present across most situations. It is often accompanied by low self-esteem, loss of interest in normally enjoyable activities, low energy, and pain without a clear cause.; Functional Maintenance Program (FMP) - Clinical program designed to maintain funtional status and well-being; Hematocrit - measures how much of your blood is made up of red blood cells; Hemoglobin - a protein in red blood cells that helps blood carry oxygen throughout the body;	F 000		

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F 000	Continued From page 2 Hepatitis B - Disease that affects the liver; Multidrug Resistant Organisms - a germ that is resistant to many antibiotics.; Parkinson's Disease - brain disorder affecting movement leading to shaking/tremors and difficulty walking; Passive Range of Motion (PROM) - An individual or equipment moves the joint through the range of motion with no effort from the patient; Pneumococcal Immunizations - Pneumonia vaccine; Pressure ulcer (PU) - sore area of skin that develops when blood supply to it is cut off due to pressure; PU Stage 2 - blister or shallow open sore with red/pink color; PU Stage 4 - an open sore so deep that muscle, tendons, ligaments, cartilage or bone can be seen; ROM - Range of Motion;. Splint - a device used for support or immobilization of a limb; Vaccination - administration of antigenic material (a vaccine) to stimulate an individual's immune system to develop adaptive immunity to a pathogen.	F 000		
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	F 585		3/23/19

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F 585	Continued From page 3 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 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,	F 585		

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F 585	Continued From page 4 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, 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	F 585		

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F 585	Continued From page 5 (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, interview and review of other facility documentation it was determined that, for one (R68) out of two sampled residents for concerns/grievances, the facility failed to thoroughly investigate the grievance and respond to the complainant in writing. Findings include: 12/27/06 - Facility policy entitled Resident Grievance Policy (last revised 11/13/17) included that the facility would provide a written summary of the results of the investigation. Review of R68's clinical record revealed: 5/7/18 - A physicians' order stated that R68 was to be given Sinemet, a medication for Parkinson's Disease, at 8:00 AM, 1:00 PM and 5:00 PM and one tablet at bedtime (scheduled for 10:00 PM). Drug information documented the purpose of Sinemet was to control the muscle stiffness, tremors, spasms and poor muscle control associated with Parkinsons' Disease. This medication is time sensitive and must be taken at regular intervals during the day. (https://www.drugs.com/mtm/sinemet.html) 6/15/18 - A grievance was submitted by e-mail by R68's Power of Attorney (POA) included that today's "breakfast dose" (usually given 7:30 AM - 8:00 AM) of the medication for Parkinson's Disease was not given until 10:20 AM. Additionaly, R68 "became angry when the nurse returned to give [R68] lunch pills at 11:30 AM	F 585	A.) Resident R68 was not negatively impacted by the deficient practice and no longer resides at the facility. B.) All residents who are noted to have a grievance voiced have the potential to be affected by this deficient practice. The Quality Assurance Nurse or designee will conduct a focus review of all newly received resident grievance forms in the past 30 days to identify any medication errors included in grievance and to ensure the grievance policy and procedure was followed and errors identified and investigated. C.) Root cause analysis revealed that the facility failed to follow the Grievance Policy and Procedure in regards to who handled the grievance and ensured follow up was completed. The Grievance Policy and Procedure was reviewed and revised to reflect the facilities current practice and to align with federal regulation. It was implemented on 2/28/19. The Staff Education Nurse or designee will conduct education for all staff employed by DVH on the updated policy and procedure for resident grievances. D.) The Quality Assurance Nurse or designee will audit all newly received resident grievance forms to ensure proper	

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F 585	Continued From page 6 because s/he realizes that an hour and 10 minutes is not an appropriate length of time between dosages." The grievance also expressed concern about the administration of time sensitive medications during off-site activities. 1/16/19 (4:05 PM - 4:30 PM) - Telephone interview with R68's POA revealed a written summary of the investigation was never received even after a meeting was held at the facility to discuss R68's medication management in August, 2018. The POA added that the prescribed times were designated by the neurological doctor treating R68's Parkinsons' Disease for maximal benefit and control of symptoms. 1/17/19 (1:25 PM - 1:50 PM) - During an interview with E5 (QA Coordinator) to discuss the grievance process in place at the time of the incident, E5 confirmed that the two doses of R68's medication were signed off as being administered close together. E5 stated this grievance was turned over to nursing and confirmed that the late timing of the 8:00 AM dose was not identified as a medication error. After the complainant emailed E5 about not receiving a written response, E5 stated that they called the complainant, documented the conversation, but did not think a letter was written. E5 printed a copy of a letter written to the complainant (saved 9/4/18 in the computer) addressing the facility response for the provision of time sensitive medications during activities, but stated the letter was never sent. E5 stated s/he realized around the time of this grievance that the process, form and policy needed revisions. E5 added that the facility was "currently awaiting	F 585	procedure has been completed with grievance response and reports of medication errors (Attachment # 1). The audit will be conducted weekly until 100% compliance is achieved for three consecutive audits. Then the audit will be conducted monthly x 3 months, if 100% compliance is achieved/maintained, the deficiency will be considered resolved. Results of the audits will be presented and discussed at the monthly facility QA Meeting, audit schedules will be adjusted as deemed necessary.	

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F 585	Continued From page 7 signatures for the new policy" and education of staff, residents, and families would need to occur. 1/17/19 at 4:05 PM - A follow-up interview with E5 (QA Coordinator) confirmed that E2 (DON) also spoke with complainant, but did not send a letter either. These findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) during the exit conference beginning at 3:20 PM on 1/23/19.	F 585		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on record review, interview and review of other facility documentation it was determined that the facility failed to implement their policy for identifying allegations of abuse for two (R44 and R15) out of two sampled residents investigated for abuse/ mistreatment. For R44 and R15, the facility failed to identify mistreatment and emotional / mental abuse. Findings include: 11/17/17 - The facility policy entitled Resident	F 607	1A.) Resident R44 was not negatively impacted by this deficient practice. Education was provided to staff members caring for R44 regarding appropriate resident specific care plan interventions. 1B.) All residents who are noted to have either self-reported or reports from any other source related to allegations of abuse and/or mistreatment have the	3/23/19

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F 607	Continued From page 8 Abuse Protection Program included guidance to"ensure each resident is free from abuse, neglect, misappropriation of resident property, corporal punishment and involuntary seclusion. - Physical abuse is the willful infliction of pain or injury to a resident. This includes, but not limited to: kicking, pinching, punching, slapping or pulling hair It also includes controlling behavior through corporal punishment. - Mental Abuse includes, but it not limited to, humiliation, harassment, threats of punishment or deprivation. - Mistreatment is the inappropriate use of medications, isolation, or physical or chemical restraints on or of a resident. - Procedure for Identifying included that facility will maintain a proactive approach for identifying events, occurences, patterns and trends that may constitute or contribute to abuse, neglect... - Components of the Program include a reporting process that supports immediate reporting of suspected abuse, neglect and misappropriation. . . . without fear of retribution. - Procedure for Report of Allegation included an employee, resident, family member, visitor, etc. have reasonable cause to believe a resident has been abused, mistreated, neglected, has had property misappropriated or has received a significant injury (an allegation is reported). Staff will immediately report allegation to their supervisor or nursing supervisor. . . ". 1. Review of R44's clinical record revealed: 1/11/18 - Care plan problem for "socially inappropriate behavior . . . non-compliance with the plan of care, unable to redirect and physical aggression. Approaches for the nurse: Offer distraction / redirection when behaviors noted and	F 607	potential to be affected by this deficient practice. The Quality Assurance Nurse or designee will conduct a focus review of all newly received allegations of potential abuse and/or mistreatment in the past 30 days to ensure timely reporting of allegations occurred. 1C.) Root Cause Analysis revealed that staff did not use appropriate resident centered care plan interventions, did not report allegations of abuse/neglect timely per facility policy and the facility abuse/neglect post-test did not verify knowledge of timely reporting allegations. The facility has adjusted the annual mandatory education test to include questioning in regards to immediate reporting of allegations of abuse/neglect as the practice. The facility failed to submit the 5 day follow up to the state survey agency (Division of Long Term Care Resident Protection). Cross refer to F607. B.) All residents who are noted to have an incident reported to the State Survey Agency, (Division of Long Term Care Resident Protection) to include a 5 day follow up have the potential to be affected by the deficient practice. The Quality Assurance Nurse or designee will conduct a focus review of all newly received state reportable incidents to assess for completion/submission of the 5 day follow up in the past 30 days. C.) Root Cause Analysis revealed that the facility did not submit the 5 day follow up	

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F 607	Continued From page 9 PRN; As needed have two staff members give care or one male staff member accessible / present to deter any inappropriate behaviors; Leave (do not compromise the resident's safety) and tell R44 that staff member will return after he stops the unacceptable behavior. Approaches for the nurse aide: Set limits on what behaviors staff will not accept from the resident; Approach resident calmly; Allow resident 10-15 minutes to calm down then re-approach; Explain all procedures, tell resident what is happening". 6/1/18 - The annual MDS Assessment documented R44 had severe cognitive impairment due to dementia and could not move his/her left arm and leg due to a stroke. 6/6/18 - The care plan problem "for potential for ineffective coping, social isolation and disturbance in self-concept related to potential abusive situation observed during medication pass. Reported that during medication administration, R44 spit out medications and staff was observed pushing ice cubes into the residents mouth and speaking in a disrespectful manner. Social worker to meet with resident weekly for one month". Review of the investigation packet revealed numerous statements: - A2 (witness): Observed E23 (LPN) saying to R44 "don't resist me, you know I am stronger than you, you only have one good arm." R44 said "stop" but R23 "proceeded to force the ice cube in his mouth, covering mouth with her hand as he turned his head away, making him take it." The resident shook his fist and said, "Get the h*ll away from me" and added "I want to escape this place."	F 607	of alleged abuse/neglect to the State Survey Agency as there was not clear identification of the responsible party. The state reportables are now reviewed daily by the Quality Assurance Nurse or designee to ensure 5 day follow up is completed. The Staff Educator or designee will conduct education for the DON, ADONs, and Nursing Supervisors on the policy and procedure for submission of the 5 day follow up of state reportable investigations. D.) The Quality Assurance Nurse or designee will audit all newly received state reportable investigations to ensure proper procedure of reporting a 5 day follow up has been completed (Attachment # 2). The audit will be conducted weekly until 100% compliance is achieved for three consecutive audits. Then the audit will be conducted monthly x 3 months, if 100% compliance is achieved/maintained, the deficiency will be considered resolved. Results of the audits will be presented and discussed at the monthly facility QA Meeting, audit schedules will be adjusted as deemed necessary.	

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F 607	Continued From page 10 - E24 (CNA): The resident (R44) was spitting out his medicine and E23 (LPN) was trying to get him to take it. The nurse (E23) was "rough" with the resident and the nurse said "I am going to send this picture to your wife so that she can see what you're doing." - E27 (CNA): The nurse (E23) informed the aide (E27) the resident "started having behaviors before dinner" and was spitting out his medications. - E23 (LPN): The nurse (E23) acknowledged giving R44 ice while touching the resident's right hand "to help keep him comfortable so that I would not get hit off guard because resident sometimes will swing and hit" . . "this was the second time" E23 tried to give R44 medication so s/he tried a different method . . and gave R44 "ice prior to give (sic) him medication and after giving him medication." 1/17/19 (4:05 PM) - E5 (QA Coordinator) delivered a copy of an incident report submitted to the State Agency and explained that the staff member who witnessed the incident on Friday 6/1/18 did not report it to the facility until 6/4/18 at 3:20 PM. E5 stated that the internal investigation did not substantiate the abuse since no one else saw it. 1/23/19 (9:45 AM) - An interview was done with E28 (SW) to discuss the emotional support provided last summer to R44. E28 confirmed that R44's was not care planned to have their right hand held down to provide care. 1/23/19 (10:00 AM) - E17 (Educator) was interviewed to obtain evidence of abuse and neglect training. Review of the annual mandatories for E23 (LPN) revealed that E23	F 607		

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F 607	Continued From page 11 completed abuse and neglect training including a test on 8/15/18. 1/23/19 (11:35 AM) - Review of additional documents showed that A2 (witness) completed abuse and neglect training during the annual mandatories on 9/1/18. The three questions about abuse and neglect on the annual mandatories did not include anything about immediate reporting allegations of abuse / neglect. The facility failed to ensure R44's allegation of abuse/ mistreatment was identified as per the Resident Abuse Protection Program policy. 2. Review of R15's clinical record revealed: 8/22/18 - Diagnoses included "recurrent depressive disorders". 10/8/18 - QA notes from a meeting to discuss a grievance about medication times between R15, E30 (SW) and E5 (QA Coordinator) included that R15 "believes s/he gets punished." 1/18/19 - Review of care plan, done by E30 (SW), documents that R15 does not feel "comfortable and secure" in the facility. 1/23/19 - During an interview at 10:47 AM, E5 (QA Coordinator) stated that the above conversation was not thought of as possible mental abuse as R15 did not persist with the statements. During the interview E5 explained that there was not a concern about the statements because R15 moved on to other complaints. E5 said that E30 (SW) was also at a meeting with R15 on 10/8/18 and would definitely	F 607		

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DELAWARE VETERANS HOME	100 DELAWARE VETERAN'S DRIVE MILFORD, DE 19963

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F 607	Continued From page 12 have identified an allegation of abuse. E5 stated that R15's mental diagnosis contributes to the statements made. 1/23/19 - During an interview at 11:13 AM, E30 (SW) stated that possible mental abuse was not identified during the 10/8/18 conversation as R15 has a history of saying that the staff do not care about residents and s/he no longer mentions feelings of being punished. E30 also explained that allegations of abuse would not go through her, that s/he was responsible for verifying and updating the psychosocial care plans. E30 also stated that R15 receives counseling services. The facility failed to identify an allegation of mental abuse. Findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) during the exit conference beginning at 3:20 PM on 1/23/19.	F 607		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to	F 609		3/23/19

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F 609	Continued From page 13 the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and review of other facility documentation, it was determined that the facility failed to inform the State Agency of a 5-day follow up of an alleged abuse investigation for one (R44) out of two residents sampled for mistreatment / abuse. Findings include: 11/17/17 - The facility policy entitled Resident Abuse Protection Program included guidance to ensure that each resident was free from abuse, neglect, misappropriation of resident property, corporal punishment and involuntary seclusion. "... An initial report of alleged abuse, neglect or misappropriation will be filed with Long Term Care Resident Protection (LTCRP) within 2 hours of the allegation . . Upon conclusion of the Nurse Investigator' follow-up investigation, findings will be reported to LTCRP (within 5 days of the initial report). . .". Cross Refer F607, Example 1. Review of R44's investigation packet revealed numerous statements:	F 609	A.) Resident R44 was not negatively impacted by the deficient practice. The facility failed to submit the 5 day follow up to the state survey agency (Division of Long Term Care Resident Protection). Cross refer to F607. B.) All residents who are noted to have an incident reported to the State Survey Agency, (Division of Long Term Care Resident Protection) to include a 5 day follow up have the potential to be affected by the deficient practice. The Quality Assurance Nurse or designee will conduct a focus review of all newly received state reportable incidents to assess for completion/submission of the 5 day follow up in the past 30 days. C.) Root Cause Analysis revealed that the facility did not submit the 5 day follow up of alleged abuse/neglect to the State Survey Agency as there was not clear identification of the responsible party. The state reportables are now reviewed daily	

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F 609	Continued From page 14 - A2 (witness): Observed E23 (LPN) saying to R44 "don't resist me, you know I am stronger than you, you only have one good arm." R44 said "stop" but R23 "proceeded to force the ice cube in his mouth, covering mouth with her hand as he turned his head away, making him take it." The resident shook his fist and said, "Get the h*ll away from me" and added "I want to escape this place." - E24 (CNA): The resident (R44) was spitting out his medicine and E23 (LPN) was trying to get him to take it. The nurse (E23) was "rough" with the resident and the nurse said "I am going to send this picture to your wife so that she can see what you're doing." - E27 (CNA): The nurse (E23) informed the aide (E27) the resident "started having behaviors before dinner" and was spitting out his medications. - E23 (LPN): The nurse (E23) acknowledged giving R44 ice while touching the resident's right hand "to help keep him comfortable so that I would not get hit off guard because resident sometimes will swing and hit" . . "this was the second time" E23 tried to give R44 medication so s/he tried a different method . . and gave R44 "ice prior to give (sic) him medication and after giving him medication." 1/17/19 (4:05 PM) - Interview with E5 (QA Coordinator), who provided a copy of the incident report submitted to the State Agency, explained that the staff member who witnessed the incident on Friday 6/1/18 did not report it to the facility until 6/4/18 at 3:20 PM. The allegation of abuse was reported within 30 minutes of the facility notification on 6/4/18.	F 609	by the Quality Assurance Nurse or designee to ensure 5 day follow up is completed. The Staff Educator or designee will conduct education for the DON, ADONs, and Nursing Supervisors on the policy and procedure for submission of the 5 day follow up of state reportable investigations. D.) The Quality Assurance Nurse or designee will audit all newly received state reportable investigations to ensure proper procedure of reporting a 5 day follow up has been completed (Attachment # 2). The audit will be conducted weekly until 100% compliance is achieved for three consecutive audits. Then the audit will be conducted monthly x 3 months, if 100% compliance is achieved/maintained, the deficiency will be considered resolved. Results of the audits will be presented and discussed at the monthly facility QA Meeting, audit schedules will be adjusted as deemed necessary.	

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F 609	Continued From page 15 Review of the State Agency electronic notification system revealed the facility failed to submit a 5-day follow up of the investigation. Finding were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) during the exit conference beginning at 3:20 PM on 1/23/19.	F 609		
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	F 657		3/23/19

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F 657	Continued From page 16 by: Based on record review and interview, it was determined that the facility failed to review and revise care plans for two (R20 and R3) out of 20 sampled residents for investigation. Findings include: Cross refer F686. 1. Review of R20's clinical record revealed the following: 8/24/17 - An Occupational Therapy order stated to place a light blue foot elevator (a round foam pillow) to be placed under R20's left forearm to relieve pressure between R20's hand and chest and to use this positioning device, at all times in and out of bed. Additionally, the left hand should be floating with no contact with any other surface. 9/20/18 - There was a new onset stage 2 PU to R20's left, second finger. 10/29/18 (Original creation date of 9/11/18) - A care plan for potential for impaired skin integrity and an actual open area to left, 2nd finger listed the goal that R20 would have no skin breakdown, despite the fact that the resident already had skin breakdown. Interventions included to use a left elbow donut (a round foam pillow) when out of bed. There was no evidence, that the facility reviewed and revised the care plan, to incorporate the intervention to use the offloading device, as documented on the above OT order dated 8/24/17, to offload R20's left hand at all times and it should be free floating. 1/22/19 at approximately 1:45 PM - An interview with E6 (RN, UM) confirmed, that the facility failed	F 657	1A.) Resident R20 was not negatively impacted by this deficient practice. The facility failed to review and revise resident s plan of care r/t potential vs actual impaired skin integrity (pressure related) and r/t intervention use of offloading device. Cross Refer to F686 1B.) All residents who are noted to have actual impaired skin integrity (pressure related) have the potential to be affected by this deficient practice. The Quality Assurance Nurse or designee will conduct a focus review of all current residents noted with pressure related skin impairment to ensure ordered interventions are reflected on their care plan. 1C.) Root Cause Analysis revealed that the facility failed to update the care plan with the occupational order as they were unfamiliar with the process. The Staff Educator or designee will pull a Physician Order report weekly to ensure all orders are reflected appropriately on the care plan. The Staff Educator or designee will conduct education for all unit managers and nursing supervisors employed by DVH on updating care plans with ordered interventions. 1D.) The Quality Assurance Nurse or designee will audit all residents who are noted to have actual impaired skin integrity (pressure related) to assess for care plan revisions and updates r/t the actual impaired skin integrity and use of	

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F 657	Continued From page 17 to revise the care plan to incorporate the device to float the left, second finger from the chest at all times and as per OT order dated 8/24/17. Cross refer F688. 2. Review of R3's clinical record revealed the following: 5/2/18 - A care plan, for R3's right sided weakness, titled, neglect: unilateral right side with a goal that the resident will not have injury to the affected side or body part, or no skin breakdown. 12/21/18 - The Functional Maintenance Program (FMP), completed by E11 (Certified Occupational Therapy Assistant/Licensed), indicated the components of the individualized program to be followed by the nursing staff: - Please apply R3's right resting hand splint during AM care and remove when resident requests or during bedtime care. - Approach/Recommendations/Precautions for implementation of FMP: Provide resident with skin checks daily. Make nursing or therapy aware if redness or any other signs of skin irritation is found. - Positioning recommendations: Provide resident with passive range of motion to right wrist, hand, and digits before putting on hand splint. The document stated, "please notify unit manager if resident is consistently unable to participate in FMP and/or there is an issue with the positioning/splinting devices." There was a lack of evidence, that the above care plan was reviewed and revised, to incorporate the above FMP interventions.	F 657	offloading devices as ordered(Attachment # 3). The audit will be conducted weekly until 100% compliance is achieved for three consecutive audits. Then the audit will be conducted monthly x 3 months, if 100% compliance is achieved/maintained, the deficiency will be considered resolved. Results of the audits will be presented and discussed at the monthly facility QA Meeting, audit schedules will be adjusted as deemed necessary. 2A.) Resident R3 was not negatively impacted by this deficient practice. The facility failed to review and revise residents plan of care r/t the resident s functional maintenance program approaches/interventions. Cross Refer to F688 2B.) All residents who are on The Functional Maintenance Program have the potential to be affected by this deficient practice. The Quality Assurance Nurse or designee will conduct a focus review of all current residents on a Functional Maintenance Program (FMP) to ensure FMP orders are noted on the care plan. 2C.) Root Cause Analysis revealed that the nurse failed to input the FMP orders as an intervention on the care plan as they were unfamiliar with the process. The Staff Educator or designee will pull a Physician Order report weekly to ensure all orders related to FMP are reflected appropriately on the care plan and follow up with individual staff members based on	

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F 657	Continued From page 18 1/22/19 at 11:35 AM - An interview with E6 (RN, UM) confirmed that the facility failed to revise the care plan to include R3's FMP approaches. Findings reviewed with E1 (NHA), E2 (DON), and E3 (ADON), during an exit conference beginning at 3:20 PM on 1/23/19.	F 657	results. The Staff Educator or designee will conduct education for all unit managers and nursing supervisors employed by DVH on The Functional Maintenance Program protocol. 2D.) The Quality Assurance Nurse or designee will audit all residents who are on The Functional Maintenance Program to ensure their care plan includes FMP interventions (Attachment # 4). The audit will be conducted weekly until 100% compliance is achieved for three consecutive audits. Then the audit will be conducted monthly x 3 months, if 100% compliance is achieved/maintained, the deficiency will be considered resolved. Results of the audits will be presented and discussed at the monthly facility QA Meeting, audit schedules will be adjusted as deemed necessary.	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to provide ADL care for a dependent resident when one (R67) out of 5 sampled residents for ADL review was left in in the wheelchair for an extended timeframe of greater than three hours in the dining room. Findings include:	F 677	A.) Resident R67 was not negatively impacted by this deficient practice and no longer resides at the facility. The facility failed to provide ADL care. B.)All residents who require assistance for repositioning and/or ADL care have the potential to be affected by this deficient	3/23/19

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F 677	Continued From page 19 Review of R67's clinical record revealed: 4/10/15 (last updated 10/24/18) - R67's care plan for ADL's related to potential for self care deficit documented that R67 was dependent for eating, transferring, toileting, grooming. 6/11/17(last updated 10/25/18) - R67's care plan for urinary incontinence related to limited mobility and decline in health - included interventions to assist with hygiene and reposition every two hours when up. 4/16/18 - An order was written for R67 not to be up in the wheelchair nor the recliner for greater than two hours. 6/11/18- A quarterly MDS assessment documented that R57 needed extensive assistance of 1 person for locomotion off the unit, hygiene and toileting. 1/22/19 9:03 AM - During an interview with R67's caregiver and responsible party it was reported that there was "an incident in the cafeteria where they left R67 sitting I think it was close to four hours." 1/23/18 9:40 AM - E5 (RN/ QA Coordinator) provided the survey team with a statement that documented, "After R67's caregiver's concerns about the events on 8/26/18 I reviewed the video cameras. Her timeline of events corresponds with the video. R67 was brought to the nurse's station (from the direction of his room) at 3:15 PM. R67's caregiver arrived at 3:49 PM. Staff assisted R67 to the dining room at 4:28 PM... The last staff member from the unit is seen leaving with another resident at 5:38 PM... A staff member	F 677	practice. The Quality Assurance Nurse or designee will conduct a focus review of all residents who require assistance with repositioning and/or require assistance with ADL cares to establish a baseline sample for audit. C.) Root Cause Analysis revealed that the staff did not turn or reposition resident in accordance with the residents plan of care as staff didn t want to interrupt the families visit. The Staff Educator or designee will conduct education for all RNs, LPNs, and CNAs employed by DVH on the policy and procedure for Repositioning Residents, resident centered care and need to provide/offer care during family visits. D.) The Quality Assurance Nurse or designee will conduct random audits of residents who require assistance with ADL care and/or repositioning to assess for proper completion of care within a two hour time frame (Attachment # 5). The audit will be conducted daily on 10% of residents for each unit until 100% compliance is achieved for three consecutive audits. Then the audit will be conducted three times a week on 10% of residents for each unit until 100% compliance is achieved for three consecutive audits. Then the audit will be conducted weekly on 10% of residents for each unit until 100% compliance is achieved over three consecutive audits. Then another audit will be conducted in one month on 10% of residents for each unit, if 100% compliance is achieved, the	

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F 677	Continued From page 20 finally returns at 6:30 PM, assisting R67 back to the unit and R67's caregiver walks toward the facility exit." During submission of this documentation, E5 confirmed that R67 was up in the wheelchair from 3:15 PM to 6:30 PM with no evidence of repositioning, or ADL care for a total of 3 hours and 15 minutes. Findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) during the exit conference beginning at 3:20 PM on 1/23/19.	F 677	deficiency will be considered resolved. Results of the audits will be presented and discussed at the monthly facility QA Meeting, audit schedules will be adjusted as deemed necessary.	
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 facility documentation it was determined that, for one (R68) out of 20 sampled residents for investigation, the facility failed to administer medications according to the prescriber's instructions and they failed to identify the medication error during a grievance investigation. Findings include: 11/16/06 - The facility policy entitled Administering Oral Medications (last revised 2/29/12) listed 7 (seven) Rights related to a medication pass including: "right resident; right medication; right	F 684	A.) Resident R68 was not negatively impacted by this deficient practice and no longer resides at the facility. Cross refer F585. B.) All residents who are administered time sensitive medication(s) have the potential to be affected by this deficient practice and/or residents who have a grievance filed related to a medication timing concern. The Quality Assurance Nurse or designee will conduct a focus review of all newly received resident	3/23/19

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F 684	Continued From page 21 time; right route; right dose; right reason or right to refuse; and right documentation". The guidelines section included: "Administer medications within one (1) hour before or after their scheduled time". The documentation section included: "The nurse administering the medication must sign the MAR immediately after administering the medications." 5/15/07 - The facility Medication Error Documentation policy (last revised 1/12/12) defined a medication error as any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional, patient or consumer . . . This includes wrong resident, wrong medication wrong route, wrong dose, wrong time, an unauthorized, omission of a drug. . . All medication errors must be reported. Cross Refer F585. Review of R68's clinical record revealed: 5/7/18 - A physicians' order stated that R68 was to be given Sinemet, a medication for Parkinson's Disease, at 8:00 AM, 1:00 PM and 5:00 PM and one tablet at bedtime (scheduled for 10:00 PM). Drug information documented the purpose of Sinemet was to control the muscle stiffness, tremors, spasms and poor muscle control associated with Parkinsons' Disease. This medication is time sensitive and must be taken at regular intervals during the day. (https://www.drugs.com/mtm/sinemet.html) 6/15/18 - A grievance submitted by e-mail by R68's Power of Attorney (POA) included that	F 684	grievance forms in the past 30 days to identify any medication errors included in grievance and to ensure any medication errors were identified and investigated. C.) Root Cause Analysis revealed that the nurse failed to administer the medication per order and the facility failed to identify/follow up on medication error reported in a grievance. The facility will conduct a focused review of all residents noted with time sensitive medications as prioritized by the medical director to establish a baseline for audit reviews. The Staff Educator or designee will provide education to all RNs and LPNS employed by DVH on the policy and procedure for administering oral medications and the medication error policy and procedure. D.) The Quality Assurance Nurse or designee will conduct random audits of the EMAR to assess for proper medication administration time frame of time sensitive medications to ensure staff is adhering to oral medication administration within the 1 hour before or after schedule time as per the administering oral medication policy and (Attachment # 6). The audit will be conducted daily on 10% of residents for each unit until 100% compliance is achieved for three consecutive audits. Then the audit will be conducted three times a week on 10% of residents for each unit until 100% compliance is achieved for three consecutive audits. Then the audit will be conducted weekly on 10% of residents for each unit until	

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F 684	Continued From page 22 today's "breakfast dose" (usually given 7:30 AM - 8:00 AM) of Sinemet was not given until 10:20 AM and the lunch pills were given at 11:30 AM. 1/16/19 (4:05 PM - 4:30 PM) - A telephone interview with R68's POA revealed that the prescribed times were designated by the neurological doctor treating R68's Parkinsons' Disease for maximal benefit and control of symptoms. 1/17/19 (1:25 PM - 1:50 PM) - E5 (QA Coordinator) confirmed during interview that the two doses of R68's Sinemet were signed off as being administered close together. E5 stated this grievance was turned over to nursing and confirmed the late timing of the 8:00 AM dose was not identified as a medication error. 1/17/19 at 4:05 PM - A Follow-up interview with E5 (QA Coordinator) revealed the 8:00 AM dose was documented as administered at 10:24 AM and the 1:00 PM dose was signed off at 12:15 PM. 1/18/19 at 12:02 PM - During an interview with E16 (RN and UM of the unit where R68 resided at the time of the grievance) revealed that s/he was unawareof the medication error related to the timing of the Sinemet on 1/17/19. E16 confirmed this medication was time sensitive and should be given as ordered. This finding was reviewed with E1 (NHA), E2 (DON) and E3 (ADON) during the exit conference beginning at 3:20 PM on 1/23/19.	F 684	100% compliance is achieved over three consecutive audits. Then another audit will be conducted in one month on 10% of residents for each unit, if 100% compliance is achieved, the deficiency will be considered resolved. Results of the audits will be presented and discussed at the monthly facility QA Meeting, audit schedules will be adjusted as deemed necessary. The Quality Assurance Nurse or designee will conduct audits of any newly received resident grievance forms related to concern of medication administration to assess for proper identification of medication errors as it may apply (Attachment # 1). The audit will be conducted weekly until 100% compliance is achieved for three consecutive audits. Then the audit will be conducted monthly x 3 months, if 100% compliance is achieved/maintained, the deficiency will be considered resolved. Results of the audits will be presented and discussed at the monthly facility QA Meeting, audit schedules will be adjusted as deemed necessary.	
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)	F 686		3/23/19

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F 686	Continued From page 23 §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview it was determined that the facility failed to provide treatment and services to promote healing of a pressure ulcer (PU) for one (R20) out of two sampled residents with PUs. Findings include: Cross refer F657, example 1. Review of R20's clinical record revealed the following: 8/24/17 - An Occupational Therapy order stated to place a light blue foot elevator (a round foam pillow) to be placed under R20's left forearm to relieve pressure between R20's hand and chest and to use this positioning device, at all times in and out of bed. Additionally, the left hand should be floating with no contact with any other surface. 9/1/18 - A new onset of a stage 2 PU to R20's left, second finger.	F 686	A.) Resident R20 was not negatively impacted by this deficient practice. The facility failed to provide treatment and services to promote healing of a pressure ulcer. Cross refer 657 example 1. B.) All residents who are noted to have actual impaired skin integrity (pressure related) have the potential to be affected by this deficient practice. The Quality Assurance Nurse or designee will conduct a focus review of all current residents noted with pressure related skin impairment to establish a baseline sample for audit completion C.) Root Cause Analysis revealed that staff was not efficient with utilizing offloading device. The Therapist or designee will create visual picture for correct use of offloading device. The facility will conduct education for all RNs,	

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F 686	Continued From page 24 1/11/19 - The most recent PU assessment documented that the PU worsened to a stage 4, although the intervention to offload the left finger was documented a completed. 1/22/19 at approximately 8:15 AM - A joint observation of R20's left hand, with E6 (RN, UM) revealed that R20's left, second finger was directly on his chest and not offloaded, as per ordered. E6 confirmed that the finger was not offloaded. E6 then adjusted the lift device and verbalized that she/he will likely need to create a visual picture for the staff, to correctly apply the lift device. Findings reviewed with E1 (NHA), E2 (DON), and E3 (ADON), during an exit conference beginning at 3:20 PM on 1/23/19.	F 686	LPNS and CNAS employed by DVH on the Pressure Ulcer policy/procedure and Repositioning Residents policy/procedure and offloading devices. D.) The Quality Assurance Nurse or designee will audit all current residents noted with pressure related skin impairment to assess for proper placement and positioning of any ordered offloading interventions (Attachment #3). The audit will be conducted weekly until 100% compliance is achieved for three consecutive audits. Then the audit will be conducted monthly x 3 months, if 100% compliance is achieved/maintained, the deficiency will be considered resolved. Results of the audits will be presented and discussed at the monthly facility QA Meeting, audit schedules will be adjusted as deemed necessary.	
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility	F 688		3/23/19

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F 688	Continued From page 25 receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined for one (R3) out of four sampled residents reviewed for limited range of motion, the facility failed to ensure appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion was provided. Findings include: Cross refer F657, example 2. Review of R3's clinical record revealed the following: 4/6/18 - A quarterly MDS assessment indicated that R3 had limited ROM affecting one side of his body, both upper and lower extremities. 10/5/18 - A subsequent quarterly MDS assessment was unchanged, with R3's ROM limitations affecting his upper and lower extremities, on one side of his body. 12/21/18 - The Functional Maintenance Program (FMP), completed by E11 (Certified Occupational Therapy Assistant/Licensed), indicated the components of the individualized program to be followed by the nursing staff: - Please apply R3's right resting hand splint during AM care and remove when resident requests or during bedtime care. - Approach/Recommendations/Precautions for implementation of FMP: Provide resident with skin checks daily. Make nursing or therapy	F 688	A.) Resident R3 was not negatively impacted by this deficient practice. The facility failed to review and revise residents plan of care r/t the resident's functional maintenance program approaches/interventions. Cross Refer to F657 B.) All residents who are on The Functional Maintenance Program have the potential to be affected by this deficient practice. The Quality Assurance Nurse or designee will conduct a focus review of all current residents on a Functional Maintenance Program (FMP) to ensure FMP orders are noted on the care plan. C.) Root Cause Analysis revealed that the nurse failed to input the FMP orders as an intervention on the care plan as they were unfamiliar with the process. The Staff Educator or designee will pull a Physician Order report weekly to ensure all orders related to FMP are reflected appropriately on the care plan and follow up with individual staff members based on results. The RN Staff Educator or designee will conduct education for all unit managers and nursing supervisors employed by DVH on The Functional Maintenance Program protocol.	

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F 688	Continued From page 26 aware if redness or any other signs of skin irritation is found. - Positioning recommendations: Provide resident with passive range of motion to right wrist, hand, and digits before putting on hand splint. The document stated, "please notify unit manager if resident is consistently unable to participate in FMP and/or there is an issue with the positioning/splinting devices." 12/21/18 through 12/31/18 - The CNA Flow Record (CNA Care Plan) listed an intervention to apply R3's right resting hand splint during AM care and remove when R3 requests and during bedtime care. There was a lack of evidence, that the facility established a system, to ensure all components of the FMP were incorporated into the CNA Flow Record to be performed by the CNAs. 1/8/19 (Original implementation date of 5/2/18) - A care plan, for R3's right sided weakness, titled, neglect: unilateral right side with a goal that the resident will not have injury to the affected side or body part, or no skin breakdown. There was a lack of evidence, that all the components of the FMP were incorporated into R3's nursing care plan. 1/15/19 at approximately 10:00 AM - R3 observed in his room without the right hand splint in place. 1/15/18 at approximately 2:20 PM - R3 was observed in his room without his hand splint. R3 stated that he was unable to apply the right hand splint and he relied on staff to apply the splint. R3's splint was sitting on the bedside table.	F 688	D.) The Quality Assurance Nurse or designee will audit all residents who are on The Functional Maintenance Program to ensure their care plan includes FMP interventions (Attachment # 4). The audit will be conducted weekly until 100% compliance is achieved for three consecutive audits. Then the audit will be conducted monthly x 3 months, if 100% compliance is achieved/maintained, the deficiency will be considered resolved. Results of the audits will be presented and discussed at the monthly facility QA Meeting, audit schedules will be adjusted as deemed necessary.	

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F 688	Continued From page 27 Observed in R3's room, was a sign that documented, "Please put right splint during AM care, remove during PM care. Check skin for redness after removal." 1/15/19 at approximately 2:35 PM - During an interview with R3's assigned CNA (E9) stated that R3 stated that he was experiencing right hand pain and he did not want the splint applied. E9 verbalized that he reported this to the assigned licensed nurse, E7 (RN). 1/15/19 at approximately 2:38 PM - An interview E7 (RN) revealed that she was not informed by E9 (CNA) of R3's refusal to wear his hand splint or that R3 was complaining of right hand pain. 1/15/19 at approximately 2:39 PM - During the above interview with E7 (RN), a new nurse (E8), who was being oriented by E7, stated that R3 told her that he did not want a CNA to apply the splint but rather, a staff from the Therapy Department. E7 replied that "I did not know that." E8 stated that the Therapy Department was not notified. 1/22/19 at 11:35 AM - An interview with E6 (RN, UM) was conducted. E6 verbalized that R3 was not receiving any passive range of motion services to his right hand, thus, confirmed, that the facility failed to incorporate all the components of R3's FMP, including PROM prior to application of the hand splint. Findings were reviewed with E1 (NHA), E2 (DON), and E3 (ADON), during an exit conference beginning at 3:20 PM on 1/23/19.	F 688		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689		3/23/19

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F 689	Continued From page 28 §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview it was determined that the facility failed to ensure the resident's environment was free from accident hazards for one (R50) out of 20 sampled residents by not removing the fall mats from the floor when the resident was out of bed. Findings include: Review of R50's clinical record revealed: Care plan: 6/5/17 ADLs (revised 1/14/19): R50 required extensive assistance with 1 staff for transferring and extensive assistance with 1 or 2 staff, using handheld assist on both sides when patient is able. 8/9/17 Elopement risk due to wandering (revised 2/29/18): Safety checks as ordered. 10/25/17 Behavior related to wandering in other resident rooms and physically striking at others (revised 2/28/18): Staff should engage in activity to prevent behaviors. Games are stored in R50's room. 5/5/18 Fall potential (revised 5/15/18): When R50 is attempting to transfer self without assistance attempt distractions such as giving papers to read, and safe objects to hold.	F 689	A.) Resident R50 was not negatively impacted by this deficient practice. The facility failed to remove the fall mats from the floor when resident was out of bed. B.)All residents who utilize fall mats have the potential to be affected by this deficient practice. The Quality Assurance Nurse or designee will conduct a focus review of all residents who are noted with fall mats to establish a baseline sample for audit completion. C.) Root Cause Analysis revealed that staff failed to fully remove fall mats from floor when the resident was out of bed. The RN Staff Educator or designee will conduct education for all RNs, LPNs and CNAs employed by DVH on fall mat removal when resident is out of bed. D.) The Quality Assurance Nurse or designee will audit all residents who utilize fall mats to ensure they are removed from floor when resident is out of bed (Attachment # 7). The audit will be conducted daily until 100% compliance is achieved for three consecutive audits. Then the audit will be conducted three times a week until 100% compliance is achieved for three consecutive audits.	

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F 689	Continued From page 29 CNA documentation included a section on safety devices listing a variety of items including clip alarm, hipsters, shin guards and geri sleeves. There was nothing in R50's care plan or the list of safety devices regarding the usage of fall mats, including the placement of the fall mats when the resident was out of bed. 12/7/18 - The quarterly MDS Assessment documented R50 had severe cognitive impairment, dementia, and he needed extensive assistance to transfer and walk in his room. 1/15/19 - An observation of R50's room at 10:50 AM found adequate spacing at the foot of the bed for a wheelchair to pass to the far side of the bed. Observations of fall mat(s) on the floor next to the far side of R50's bed when the resident was out of bed self-propelling up and down both hallways, and intermittently leaving the hallway toward other resident rooms: - 1/15/19: 1 mat at 10:50 AM, outer door closed. - 1/17/19: 1 mat at 8:15 AM and 11:55 AM, outer door closed. - 1/18/19: 2 mats on top of each other at 9:25 AM; outer door open. 1/18/19 (12:20 PM) - Interview with E16 (RN, UM) revealed that fall mats should be propped up against the wall on the far side of the bed when R50 was OOB. The above observations were reviewed with E16 and she stated she would look into it. Findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) during the exit conference beginning at 3:20 PM on 1/23/19.	F 689	Then the audit will be conducted weekly until 100% compliance is achieved over three consecutive audits. Then another audit will be conducted in one month. If 100% compliance is achieved, the deficiency will be considered resolved. Results of the audits will be presented and discussed at the monthly facility QA Meeting, audit schedules will be adjusted as deemed necessary.	

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F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined that for one (R47) out of three residents sampled for pain. The facility failed to assess pain and provide interventions as indicated. Findings included: The pain management standards were approved by the American Geriatrics Society in April 2002 which included: appropriate assessment and management of pain; assess for pain on each presentation, assessment in a way that facilitates regular reassessment and follow-up; use synonyms for pain (burning, aching, soreness, discomfort).perform comprehensive evaluation for underlying cause of pain, pain characteristics, consider patient's report as the most reliable evidence of pain intensity. collect data to monitor the effectiveness and appropriateness of pain management. The facility policy on pain management last reviewed 12/5/13 indicated that : -Pain will be assessed using the numerical score of 0-10. - Non-pharmacological interventions may be attempted prior to medicating for pain if residents condition situation allows and those may include but not be limited to: repositioning, offering fluids, light massage.	F 697	A.) Resident R47 was negatively impacted by this deficient practice. The facility failed to provide evidence that pain management was consistent with professional standards of practice. B.) All residents who are noted to have pain have the potential to be affected by this deficient practice. The Quality Assurance Nurse or designee will conduct a focus review of the q shift pain check in the past 30 days to establish a baseline assessment of any resident who may be noted with complaints of pain. Any complaints of pain which appear not addressed will be investigated and followed up accordingly. C.) Root Cause Analysis revealed that the nurse failed to thoroughly assess resident s pain. The Pain Management Policy and Procedure was reviewed and revised. The RN Staff Educator or designee will conduct education for all RNs and LPNs employed by DVH on the revised policy and procedure for pain management and process for assessing for pain.	3/23/19

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F 697	Continued From page 31 -At a minimum each resident will be asked if he/she is experiencing pain once per shift... If pain is indicated that requires the use of a PRN intervention, this will be documented on the pain flow sheet and the EMAR. Pain will be assessed using the numerical score of 0-10 for verbal and non-verbal residents. The following was reviewed in R47's clinical record and other documentation as indicated: 6/11/18 - An annual MDS assessment coded R47 as cognitively intact. 7/11/18 - R47 had an order written for Ibuprofen daily as needed for mild to moderate pain. 8/18/18 An order was written for R47 to receive an antifungal cream every 12 hours at 9:00 AM and 9:00 PM to his penis and affected areas. On 8/21/18 the administration time for this medication was changed to 6:00 AM and 6:00 PM. 8/22/18 - A nurses note documented redness to R47's penis had a treatment in progress. 8/24/18 at 12:06 AM - E19 (RN supervisor) documented in a grievance form, "received a call from [R47's] caregiver. Caregiver states that R47 called him and stated the nurse refused to help him by giving him cream to his tender/reddened area. Caregiver stated he would like it addressed." 8/26/18 - E20 (RN) documented in a written statement that "E21 (CNA) came to me some time after I got report and mention that R47 wanted cream put on his penis. I noticed he did	F 697	D.) The Quality Assurance Nurse or designee will audit q shift pain check to ensure proper procedure has been completed to assess and address complaints of pain. (Attachment # 8). The audit will be conducted daily on 10% of residents for each unit until 100% compliance is achieved for three consecutive audits. Then the audit will be conducted three times a week on 10% of residents for each unit until 100% compliance is achieved for three consecutive audits. Then the audit will be conducted weekly on 10% of residents for each unit until 100% compliance is achieved over three consecutive audits. Then another audit will be conducted in one month on 10% of residents for each unit, if 100% compliance is achieved, the deficiency will be considered resolved. Results of the audits will be presented and discussed at the monthly facility QA Meeting, audit schedules will be adjusted as deemed necessary.	

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F 697	Continued From page 32 have a scheduled cream...the cream could not be put on until after midnight... I explained to R47 that the only cream he had was scheduled and was signed off as given and that due to it being scheduled twice a day I could not give that cream at that time...R47 mentioned no complaints or pain nor did he appear to be in any distress." Review of documentation in the the nurses notes did not indicate that E20 asked whether R47 was in pain at the time of his complaint, nor was there any indication that R47 was made aware of when the next dose of cream could be administered. The every shift documentation in the EMAR documented a "no" response to pain. During a telephone interview on 1/25/18 at 10:58 AM E20 declined to provide a verbal statement and confirmed that the events occurred exactly as documented in the written statement. When asked if a pain assessment was completed at the time of R47's complaint, E20 stated "whatever I wrote is exactly how it happened". 9/4/18 - A written statement from E21 (CNA) documented that R47 "rang his bell about 11:15 PM and said he wanted some cream on his penis. He told me that the nurse was supposed to put the cream on earlier...after resident told me about his cream I told the nurse. The nurse just got report but when I let her know she put cream in a cup and told me that she could put it on after midnight." 12/12/18 - R47's care plan for pain was reviewed, and there were multiple interventions including to assess physical signs and symptoms of pain daily, administer pain medications daily, note effectiveness and adverse reactions, encourage adequate rest, position for comfort, support with pillows, provide quiet, and report pain indicators.	F 697		

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F 697	Continued From page 33 During an interview on 1/18/19 at 10:16 AM with R47's caregiver / responsible party it was reported that "in August R47 called and said to me he was in pain, I called the nurses station and the way it was presented to me was that someone came in, she answered the bell but did not give him any pain medication nor did she explain why or why not. When I spoke to the staff they said, that nurse said R47 didn't look to be in pain; my question was why didn't she ask him." During an interview on 1/18/19 at 1:38 PM with E18 (RN) it was reported that E20 (RN) was out of work on bereavement leave and may be unavailable for an interview. The facility failed to provide evidence that they ensured R47 was provided pain management consistent with professional standards of practice, when on 8/24/18, R47 requested a cream for penile discomfort, and his assigned nurse E20 did not assess R47's pain, offer any non-pharmalogical intervention in response to pain, offer any alternative as needed pharmacological intervention, provide education/explanation on why R47 could not be given his cream and state when he could receive the next dose. Findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) during the exit conference beginning at 3:20 PM on 1/23/19.	F 697		
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	F 730		3/23/19

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F 730	Continued From page 34 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 review of facility documentation and interview it was determined that for two (E9 and E25) out of 6 CNA performance reviews, the facility failed to ensure they were conducted every 12 months. Findings include: The latest performance reviews for 6 randomly selected CNAs was requested and revealed the following hire date and last performance review date: E25: 9/27/10 (1/17/17, last performance review) E9: 4/20/09 (No performance review provided by the facility) 1/23/19 at approximately 3:00 PM - E2 (DON) explained that the performance reviews were in progress, but not yet completed, for 2018. E2 stated they were usually done in December of each year. Findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) during the exit conference beginning at 3:20 PM on 1/23/19.	F 730	A.) The facility failed to complete yearly Nurse s Aide performance review for E25 and E9. B.)All CNA staff has the potential to be affected by this deficient practice. The Quality Assurance Nurse or designee will conduct a focus review of all CNA staff performance reviews to ensure they are current. Those not current will be completed to be in compliance. C.) Root Cause Analysis revealed that all CNA performance reviews are due at the same time which overloaded the management. Moving forward the CNA performance reviews will be completed annual based on hire date. The RN Staff Educator or designee will conduct education for Unit Managers on completion of annual performance reviews for CNA staff. D.) The Director of Nursing or designee will audit CNA performance reviews to ensure timely completion (Attachment # 9). The audit will be conducted weekly until 100% compliance is achieved for three consecutive audits. Then the audit will be conducted monthly x 3 months, if 100% compliance is achieved/maintained, the deficiency will be considered resolved.	

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F 730	Continued From page 35	F 730	Results of the audits will be presented and discussed at the monthly facility QA Meeting, audit schedules will be adjusted as deemed necessary.	
F 744 SS=D	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility failed to provide dementia care in a manner that maintained the mental well-being for one (R50) out of three sampled residents for dementia review. Findings include: 6/5/17 - R50 was admitted to the facility with dementia and severe cognitive impairment. 10/25/17 - A care plan for behaviors included physically striking out at staff and other residents, wandering in other resident rooms and refusal of care. Approaches included if unable to redirect behaviors, maintain safety, give resident some time and re-approach at a later time. Resident enjoys talking and interaction, seeing her name written in paperwork, and engaging in activity (matching cards, colors, writing, reading, etc.). 1/17/19 at 9:05 AM - E23 (LPN) was observed arguing with R50 in the dining room during the morning medication pass. R50 said "I took it [medicine]." and R23 said "No, you didn't." R50	F 744	A.)Resident R50 was not negatively impacted by this deficient practice. The staff member was educated on resident centered interventions. The facility failed to provide dementia care in a manner that maintained the mental well-being for a resident. B.) All residents who have a diagnosis of dementia have the potential to be impacted by this deficient practice. The Quality Assurance Nurse or designee will conduct a focus review of all RN and LPN education files to assess for completion of dementia training. Education will be provided to ensure compliance with annual Dementia Training. C.) Root Cause Analysis revealed that the nurse did not utilize his/her knowledge from Dementia Training and did not utilize resident centered interventions. The facility will conduct education for all RNs and LPNs employed by DVH on dementia care and utilizing effective resident centered interventions.	3/23/19

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F 744	Continued From page 36 replied "Yes, I did." and E23 stated "No, this is the first time." The nurse and resident's voice became louder as this banter continued. Eventually E23 left the resident alone, to re-approach later. 1/23/19 (around 10:05 AM)- During an interview with E16 (RN, UM) the aforementioned observation was described and E16 indicated that E23 (LPN) had worked on the dementia unit for some time and offered no explanation. This finding was reviewed with E1 (NHA), E2 (DON) and E3 (ADON) during the exit conference beginning at 3:20 PM on 1/23/19.	F 744	D.) The RN Staff Educator or designee will audit that all RNs and LPNs who work at DVH receive the dementia care and utilizing effective resident centered intervention training. The audit (attachment # 10) will be conducted weekly until 100% of all RNs and LPNs have received training. Once 100% of all RNs and LPNs employed by DVH have received the training the deficiency will be considered resolved. Results of the audits will be presented and discussed at the monthly facility QA Meeting, audit schedules will be adjusted as deemed necessary.	
F 770 SS=D	Laboratory Services CFR(s): 483.50(a)(1)(i) §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. This REQUIREMENT is not met as evidenced by: Based on record reviews, interviews and review of facility documents as indicated, it was determined that the facility failed to meet the needs of laboratory services for one (R39) out of five sampled residents, for unnecessary medication review. Findings include: Review of R39's clinical record revealed:	F 770	A.)Resident R45 was not negatively impacted by this deficient practice. The facility failed to meet the needs of laboratory services. B.)All residents who get lab work completed in the facility have the potential to be affected by this deficient practice. The Quality Assurance Nurse or designee	3/23/19

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F 770	Continued From page 37 10/23/18 12:52 PM - A physician ordered blood work, scheduled every six months for January and July with a start date of 1/14/19. Review of R39's clinical record lacked evidence of results for the above ordered laboratory services. 1/14/19 - Review of the Daily Lab Log, in the Green Unit revealed that the laboratory technician's initials and a date of 1/14/19 was documented, indicating that the lab was drawn, however, the column for "Lab received" was left blank. 1/23/19 at approximately 2:30 PM - During an interview with E2 (DON), E2 confirmed that the facility had no evidence of the results of the the above laboratory services. E2 stated that the facility had no written policy and procedure, regarding obtaining quality and timely laboratory services. Findings were reviewed with E1 (NHA), E2, and E3 (ADON), during an exit conference beginning at 3:20 PM on 1/23/19.	F 770	will conduct a focus review on all lab orders within the last 30 days to ensure results were obtained. C.)Root Cause Analysis revealed that the nursing staff did not follow the process to ensure lab results were received by the facility. The facility has created and implemented a protocol for obtaining and reporting lab results. The RN Staff Educator or designee facility will conduct education with all nurses on Laboratory Services Protocol. D.) The Quality Assurance Nurse or designee will audit laboratory orders and results to ensure they are received (Attachment # 11). The audit will be conducted daily until 100% compliance is achieved for three consecutive audits. Then the audit will be conducted three times a week until 100% compliance is achieved for three consecutive audits. Then the audit will be conducted weekly until 100% compliance is achieved over three consecutive audits. Then another audit will be conducted in one month. If 100% compliance is achieved, the deficiency will be considered resolved. Results of the audits will be presented and discussed at the monthly facility QA Meeting, audit schedules will be adjusted as deemed necessary.	
F 773 SS=D	Lab Srvcs Physician Order/Notify of Results CFR(s): 483.50(a)(2)(i)(ii) §483.50(a)(2) The facility must- (i) Provide or obtain laboratory services only when	F 773		3/23/19

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F 773	Continued From page 38 ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined, for one (R45) out of five residents sampled for unnecessary medication review, the facility failed to promptly notify the ordering medical practitioner of laboratory results that fell outside of clinical reference ranges. In addition, the facility failed to have a policy and procedures, for notification of the practitioner, when laboratory results fall outside of the clinical reference range. Findings include: Review of R45's clinical record revealed: 1/3/19 - Laboratory report with out of range results: - hemoglobin of 10.6 (Low). Normal range of 13.0-17.7 - hematocrit of 31.1 (Low). Normal range of 37.5 -51.0 This report included the initials of E15 (NP) with a date of 1/4/19. 1/7/19 - An order was written for a hemoglobin and hematocrit to be completed on 1/16/19. Review of R45's clinical record lacked evidence	F 773	A.) Resident R45 was not negatively impacted by this deficient practice. The facility failed to promptly notify the ordering medical practitioner of lab results that fell outside of range and failed to have a policy and procedure for practitioner notification of out of range lab results. B.) All residents who get lab work completed in the facility have the potential to be affected by this deficient practice. The Quality Assurance Nurse or designee will conduct a focus review on all lab orders within the last 30 days to ensure results were obtained and out of range results were reported to the provider. C.) Root Cause Analysis revealed that the nursing staff did not follow the process to ensure lab results were received by the facility. The facility has created and implemented a protocol for obtaining and reporting lab results. The RN Staff Educator or designee facility will conduct education with all nurses on Laboratory	

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F 773	Continued From page 39 of results for the 1/16/19 ordered laboratory services. 1/16/19 - Review of the Daily Lab Log, in the Green Unit revealed that the laboratory technician's initials and a date of 1/16/19 was documented, indicating that the lab was drawn, however, the column for "Lab received" was left blank. 1/23/19 at approximately 9:15 AM - During an interview with E13 (OSS) revealed that the laboratory results were sent to the facility from the contracted laboratory service. Once the facility obtains the results, the "Lab received" column of the Daily Lab Log was updated with the date results were received and the initial's of the staff member who received the results. E13 confirmed there were no results of the 1/16/19 laboratory tests were received by the facility and proceeded to access the contracted laboratory services' electronic system. E13 was able to locate the results in the electronic system and printed the laboratory results to the surveyor. 1/23/19 at approximately 9:45 AM - During an interview with the ordering practitioner, E15 (NP) stated that she was unaware of the results of the 1/16/19 ordered laboratory services until this was provided to her by the surveyor during this interview. E15 stated the results remained out of range, although with a slight increase in the hemoglobin to 10.8 and hematocrit to 33.2. 1/23/19 at approximately 2:30 PM - During an interview with E2 (DON), E2 confirmed that the facility did not have the 1/16/19 laboratory tests until the surveyor's inquiry on 1/23/19. Additionally, the facility did not have a policy and	F 773	Services Protocol. D.) The Quality Assurance Nurse or designee will audit laboratory orders and results to ensure they are received and out of range results were reported to the provider (Attachment # 11). The audit will be conducted daily until 100% compliance is achieved for three consecutive audits. Then the audit will be conducted three times a week until 100% compliance is achieved for three consecutive audits. Then the audit will be conducted weekly until 100% compliance is achieved over three consecutive audits. Then another audit will be conducted in one month. If 100% compliance is achieved, the deficiency will be considered resolved. Results of the audits will be presented and discussed at the monthly facility QA Meeting, audit schedules will be adjusted as deemed necessary.	

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F 773	Continued From page 40 procedure for notification of the practitioner when the laboratory results that fall outside of the clinical reference range. Findings reviewed with E1 (NHA), E2, and E3 (ADON), during an exit conference beginning at 3:20 PM on 1/23/19.	F 773		
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that for two (R14 and R41) out of 10 residents observed on the Gold unit during a random lunch observation, the facility failed to offer a substitute when meal items served were not eaten. Findings include: 1/15/19 (11:55 AM - 12:40 PM) - Random lunch observation in the Gold (locked dementia unit) dining room: a. Review of R14's clinical record revealed: 10/31/18 - The admission MDS Assessment coded R14 as requiring supervision with eating to provide meal oversight, and R14 required	F 806	A.)Resident R14 and R41 were not negatively impacted by this deficient practice. The facility failed to offer a substitute meal when items served were not eaten. B.) All residents have the potential to be affected by this deficient practice. Future residents will be protected from this deficient practice by taking correct actions outline below in C. C.) Root Cause Analysis revealed that staff did not offer alternative foods to resident(s) when intake was low. The facility has revised the meal intake form to	3/23/19

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F 806	Continued From page 41 encouragement or cueing. R14 was served cole slaw, french fries, crab cake, and a roll at 12:10 PM and sat staring at the food for several minutes. E31 (Administrative Assistant) verbally cued the resident to eat french fries. R14 slowly ate one french fry. E31 explained to E32 (LPN orientee) that "we keep peanut butter and jelly" and was used to eating that. R14 began eating the roll and was served ice cream. After pushing the plate with the meal aside, the resident picked up and looked into the bowl containing cole slaw then placed it on the table. R14 finished the ice cream then stood at 12:34 PM and removed the clothing protector. E33 (LPN) guided the resident to walk to a lounge chair in the activity area. R14 only ate 1 french fry, ice cream and roll. E33 cleared the dishes from the table. R14 was not offered an alternative. b. Review of R41's clinical record revealed: 11/23/18 - A quarterly MDS Assessment coded R14 as requiring supervision with eating to provide oversight, and to provide encouragement or cueing. R41 was served cole slaw, french fries, crab cake, a roll and ice cream. R41 ate the crab cake and ice cream but did not touch the other three food items. E31 (Administrative Assistant) cleared dishes without offering R41 any alternative food items. 1/18/19 (around 12:20 PM) - The observation was reviewed with E16 (RN, UM). Findings were reviewed with E1 (NHA), E2 (DON)	F 806	include a column on offering alternative food/meal if 25% or less of their meal is eaten. The RN Staff Educator or designee will educate Nursing and CNA staff on offering substitute meal when resident has eaten 25 percent or less of their meal. D.) The Unit Manager or designee will conduct random audits during meal times to assess for any residents who have consumed 25 percent or less of their provided meal and to ensure they have been offered or provided an alternative choice as necessary (Attachment # 12). The audit will be conducted daily until 100% compliance is achieved for three consecutive audits. Then the audit will be conducted three times a week until 100% compliance is achieved for three consecutive audits. Then the audit will be conducted weekly until 100% compliance is achieved over three consecutive audits. Then another audit will be conducted in one month. If 100% compliance is achieved, the deficiency will be considered resolved. Results of the audits will be presented and discussed at the monthly facility QA Meeting, audit schedules will be adjusted as deemed necessary.	

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F 806	Continued From page 42 and E3 (ADON) during the exit conference beginning at 3:20 PM.	F 806		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, it was determined that the facility failed to store food under sanitary conditions. Findings include: 1/17/19 beginning at 10:55 AM - An observation in the Green Unit, revealed E29 (Food Services Staff), transporting lunch items from the remote temporary kitchen to the unit's activity room. Three pies were being transported and were uncovered. 1/17/19 at approximately 10:58 AM - An interview	F 812	A.)Upon notification, E 29 covered the pies with plastic wrap to correct the finding. No residents were negatively affected by this deficient practice. B.) All residents have the potential to be affected by this deficient practice. C.Root cause analysis revealed that staff is unfamiliar with food storage and transportation regulations as they relate to the new dining & food service process.	3/23/19

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F 812	Continued From page 43 with E29 (Food Services Staff), confirmed that the pies should have been covered during transportation. Findings reviewed with E1 (NHA), E2 (DON), and E3 (ADON), during an exit conference beginning at 3:20 PM on 1/23/19.	F 812	The Food Service Director or designee will conduct a focused review of food on transport carts to ensure compliance with food that is stored/transported is covered in compliance with professional standards. The Food Service Director or designee will educate Food Services Staff on Safe Transportation of Food and Beverage Items. D.) The Food Service Director or designee will provide training to the Dietary department. The Director or designee will conduct random audits to ensure food is transported/stored in a sanitary manor (Attachment #13). The audit will be conducted daily until 100% compliance is achieved for two consecutive weeks. Then the audit will be conducted weekly until 100% compliance is met for 2 consecutive weeks. The audit will then be conducted monthly until 100% compliance is met for 2 consecutive months. At this time the deficiency will be considered resolved. Results of the audits will be presented and discussed at the monthly facility QA Meeting, audit schedules will be adjusted as deemed necessary.	
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	F 880		3/23/19

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F 880	Continued From page 44 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 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	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085051	A. BUILDING _____ B. WING _____	C 01/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 45 must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and review of other facility documentation it was determined that the facility failed to review the infection prevention and control program policies and procedures annually. Findings include: Record review of the Infection Prevention and Control Program policies and procedures on 1/22/19 revealed the following procedures were not reviewed annually: a. Infection Prevention and Control Program: dated 12/14/06; reviewed/revised 9/11/17. b. Antibiotic Stewardship Program: dated 11/23/17; not reviewed. c. Infection Prevention and Control Communication: dated 12/14/06; reviewed/revised 9/11/17.	F 880	A.) No residents have been found to have been affected by this deficient practice of failure to review the Infection Control Policies on an Annual Basis. The following policies were cited as being deficient and have been reviewed and were revised as needed: a. Infection Prevention and Control Program (Exhibit 880-1) b. Antibiotic Stewardship Program (Exhibit 880-2) c. Infection Prevention and Control Committee (Exhibit 880-3) d. Flu Vaccination (Use of Masks) (Exhibit-4) e. Clostridium Difficile (Exhibit 880-5) f. Hand Hygiene (Exhibit 880-6) g. Hepatitis B for Staff (Exhibit 880-7)	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 880	Continued From page 46 d. Flu Vaccination - (staff use of) masks: dated 4/7/16; reviewed/revised 7/7/16. e. Clostridium-difficile: dated 1/15/06, reviewed/revised 12/17/12. f. Hand Hygiene: dated April 2006; reviewed/revised 9/11/17. g. Hepatitis B Vaccination for Employees: dated 2006; reviewed/revised 4/18/13. h. Pneumococcal Immunizations - residents: dated 2006; reviewed/revised 9/11/17. i. Multidrug Resistant Organisms: dated 2006; reviewed/revised 1/31/17. 1/22/19 at approximately 12:00 PM: E3 (ADON) confirmed the above findings. Findings were reviewed with E1 (NHA), E2 (DON) and E3 during the exit conference beginning at 3:20 PM on 1/23/19.	F 880	h. Pneumococcal Immunizations Residents (Exhibit 880-8) i. Multidrug Resistant Organisms (Exhibit 880-9) B.) All residents have the potential to be affected by this deficient finding. Residents are at risk to develop infections due to the inappropriate application of infection control measures. C.) Root Cause Analysis revealed the lack of knowledge of review and revision requirements for infection control policy and procedures. RN Infection Control Practitioner or designee will review all other infection control policy and procedures to determine if any others are out of compliance. If identified will be reviewed and/or revised by 3/23/19. RN Infection Control Practitioner will create an infection control policy update calendar which will be submitted to Quality Assurance Committee quarterly. D.) The Infection Preventions will audit all infection control policies and procedures monthly to verify all are up to date with annual review/revision. Monthly audit will continue until 3 consecutive audits reach 100% compliance. Then audits will be completed quarterly until 100% compliance is reached. Then audits will be completed biannually until 100% compliance is reached. Finally, audits will be completed yearly to ensure compliance. Audit results will be brought through the Quality Assurance Committee.	

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

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

STATE SURVEY REPORT

NAME OF FACILITY: Delaware Veterans Home

DATE SURVEY COMPLETED: January 23, 2019

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 and complaint visit survey was conducted at this facility from January 15, 2019 through January 23, 2019. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census the first day of the survey was 67. The investigated sample size was 36. Abbreviations and Definitions used in this report are as follows: NHA - Nursing Home Administrator; DON - Director of Nursing; ADON - Assistant Director of Nursing; RN - Registered Nurse; LPN - Licensed Practical Nurse; MD - Medical Doctor; NP - Nurse Practitioner; RNAC - Registered Nurse Assessment Coordinator; CNA - Certified Nurse's Aide; SW - Social Worker; QA - Quality Assurance; UM - Unit Manager; CNA flow sheet - a form that details care to be provided for each specific resident assigned; ADL'S - Activities of daily living- task needed for daily living , such as dressing, hygiene, eating, toileting, bathing; EHR - Electronic Health Record; EMR - electronic medication record; eMar - electronic medication administration record; IPCP-infection prevention and control program; MDS - Minimum Data Set; standardized assessment forms used in nursing homes;		

Provider's Signature William Peterson Title DIRECTOR Date 2/27/2019

NAME OF FACILITY: Delaware Veterans Home

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	OOB - Out of Bed; OSS - Operation Support Specialist; POA - Power of Attorney; PRN - as needed; Clostridium-difficile - bacterial overgrow that releases toxins that attack the lining of the intestines; Dementia - chronic disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning; Depressive Disorder - also known as depression, is a mental disorder characterized by at least two weeks of low mood that is present across most situations. It is often accompanied by low self-esteem, loss of interest in normally enjoyable activities, low energy, and pain without a clear cause; Functional Maintenance Program (FMP) - Clinical program designed to maintain functional status and well-being; Hematocrit - measures how much of your blood is made up of red blood cells; Hemoglobin - a protein in red blood cells that helps blood carry oxygen throughout the body; Hepatitis B - Disease that affects the liver; Multidrug Resistant Organisms - a germ that is resistant to many antibiotics; Parkinson's Disease - brain disorder affecting movement leading to shaking/tremors and difficulty walking; Passive Range of Motion (PROM) - An individual or equipment moves the joint through the range of motion with no effort from the patient; Pneumococcal Immunizations - Pneumonia vaccine; Pressure ulcer (PU) - sore area of skin that develops when blood supply to it is cut off due to pressure; PU Stage 2 - blister or shallow open sore with red/pink color;		

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	PU Stage 4 - an open sore so deep that muscle, tendons, ligaments, cartilage or bone can be seen; ROM - Range of Motion; Splint - a device used for support or immobilization of a limb; Vaccination - administration of antigenic material (a vaccine) to stimulate an individual's immune system to develop adaptive immunity to a pathogen. An emergency preparedness survey was also conducted during the same time period. There were no emergency preparedness deficiencies identified based on observation and interviews.		
3201	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.0	**Scope**		
3201.2.0	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** This requirement is not met as evidenced by: Cross Refer to the CMS 2567-L survey completed January 23, 2019: F585, F607, F609, F657, F677, F684, F686, F688, F689, F697, F730, F744, F770, F773, F806, F812 and F880. **Personnel Administrative**	Cross Refer to CMS 2567-L survey Completed January 23, 2019: F585, F607, F609, F657, F677, F684, F686, F688, F689, F697, F730, F744, F770 F773, F806, F812 and F880.	

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3201.5 **3201.5.6** **3201.5.6.1**	**Dementia Training** **Nursing facilities that provide direct healthcare services to persons diagnosed as having Alzheimer's disease or other forms of dementia shall provide dementia shall provide dementia specific training each year to those healthcare providers who participate in continuing education programs. This section shall not apply to persons certified to practice medicine under the Medical Practice Act, Chapter 17 of Title 24 of the Delaware Code.** Based on interview and review of other facility documentation it was determined that the facility failed to provide dementia specific training in the past year to two (E34 and E35) out of 12 randomly selected healthcare providers reviewed. Findings include: E18 (RN, QA) completed and returned the necessary Dementia Training request form on 1/22/19 at 12:30 PM. E18 confirmed that the facility was unable to show documentation of dementia specific training in the past year to E34 (PT) and E35 (PT). These findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) during the exit conference beginning at 3:20 PM on 1/23/19.	A.) Facility failed to provide dementia training to E34 and E35. No resident was impacted by this deficient practice. B.) All residents who have a diagnosis of dementia have the potential to be impacted by this deficient practice. Residents will be protected from this deficient practice by taking the corrective actions outlined below in C. C.) The facility will conduct a focus review of all contracted therapy staff education files to assess for completion of dementia training. The facility will ensure the completion of dementia training for any contracted therapy staff found to be out of compliance. DVH will ensure the compliance with annual dementia training for the facility contacted therapy staff. D.) The Staff Development Department or designee will audit that all contracted therapy staff who work at DVH will receive their annual mandatory dementia training (Attachment #1). The audit will be conducted weekly until 100% compliance is achieved for three consecutive audits. Then the audit will be conducted monthly x 3 months, if 100% compliance is achieved/maintained, the deficiency will be considered resolved. Results of the audits will be presented and discussed at the monthly facility QA Meeting, audit schedules will be adjusted as deemed necessary.	
16 Del. C. **Chap. 11** **Subchapter VII** **§ 1162**	**Health and Safety – Regulatory Provisions Concerning Public Health** **Long-Term Care Facilities and Services Minimum Staffing Levels for Residential Health Facilities** **Nursing staffing. (a) Every residential health facility must at all times provide a staffing level adequate to meet the care needs of each resi-**	A.) Facility failed to conspicuously display the names and titles of the direct nursing caregivers assigned to each unit and the nursing supervisors on duty each shift. No resident was negatively impacted by this deficient practice.	

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	dent, including those residents who have special needs due to dementia or a medical condition, illness or injury. Every residential health facility shall post, for each shift, the names and titles of the nursing services direct caregivers assigned to each floor, unit or wing and the nursing supervisor on duty. This information shall be conspicuously displayed in common areas of the facility, in no fewer number than the number of nursing stations. Every residential health facility employee shall wear a nametag prominently displaying his or her full name and title. Personnel hired through temporary agencies shall be required to wear photo identification listing their names and titles. Based on observation and interview, it was determined that the facility failed to conspicuously display, in common areas of each of the 3 nursing units, the names and titles of the nursing direct caregivers assigned to each unit and the nursing supervisor on duty for each shift. Findings include: 1/15, 1/16, 1/17, 1/18 and 1/22/19: Observations of the Red, Gold and Green resident units' common areas revealed that the required staffing information was not posted. The Red and Green units has no staffing posted; the Gold unit had the names of the nurses and CNAs posted on a white board, but did not include if the nurse was a RN or LPN or the nursing supervisor. 1/22/19 at 11:55 AM - Interview with E36 (RN, Nurse Supervisor) confirmed the required staffing information was not conspicuously display in common areas on the three nursing units. E36 pointed out that in each resident's room on the white erase boards the assigned nurse and CNA are written each shift, and that the staff assignments are kept on clipboards or in notebooks on the units.	B.) All residents have the potential to be impacted by this deficient practice. Residents will be protected from this deficient practice by taking the corrective actions outlined below in C. C.) The facility has adjusted the daily assignment sheets to allow for display the names and titles of the direct nursing caregivers assigned to each unit and the nursing supervisors on duty each shift. The facility will post assignment sheets daily on each unit. The facility will conduct education for nursing supervisors and unit managers employed by DVH on proper completion and posting of the daily assignment sheet. D.)The Director of nursing or designee will audit to ensure the posting of daily assignment sheets on each unit (Attachment # 2). The audit will be conducted daily until 100% compliance is achieved for three consecutive audits. Then the audit will be conducted three times a week until 100% compliance	

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	These findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) during the exit conference beginning at 3:20 PM on 1/23/19.	is achieved for three consecutive audits. Then the audit will be conducted weekly until 100% compliance is achieved over three consecutive audits. Then another audit will be conducted in one month. If 100% compliance is achieved, the deficiency will be considered resolved. Results of the audits will be presented and discussed at the monthly facility QA Meeting, audit schedules will be adjusted as deemed necessary.	

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