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

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

STATE SURVEY REPORT

NAME OF FACILITY: Delaware Veterans Home

DATE SURVEY COMPLETED: April 25, 2024

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. A Recertification, Complaint and Emergency Preparedness survey was conducted by Healthcare Management Solutions LLC on behalf of the State of Delaware, Department of Health and Social Services, Division of Health Care Quality. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B. Survey Dates: 04/22/24 to 04/25/24. Survey Census: 66 Sample size: 18 Supplemental Residents: 0		
3201	**Regulations for Skilled and Intermediate Care Nursing Facilities**		
3201.1.0	**Scope**		
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:** Cross Refer to the CMS 2567-L survey completed April 25, 2024: F600, F623 and F880.		

Provider's Signature Handy Hutter Title Administrator Date 5.10.2024

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 04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELAWARE VETERANS HOME	100 DELAWARE VETERANS BLVD MILFORD, DE 19963

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E 000	Initial Comments A Recertification, Complaint and Emergency Preparedness survey was conducted by Healthcare Management Solutions LLC on behalf of the State of Delaware, Department of Health and Social Services, Division of Health Care Quality. The facility was found to be in compliance with 42 CFR 483.73	E 000		
F 000	INITIAL COMMENTS A Recertification, Complaint and Emergency Preparedness survey was conducted by Healthcare Management Solutions LLC on behalf of the State of Delaware, Department of Health and Social Services, Division of Health Care Quality. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B. Survey Dates: 04/22/24 to 04/25/24. Survey Census: 66 Sample size: 18 Supplemental Residents: 0	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.	F 600		5/17/24

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

Electronically Signed | 05/17/2024

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

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F 600	Continued From page 1 §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interview, record review, and policy review, the facility failed to protect two of three residents (Resident (R) 51, R63), reviewed for abuse, when facility nursing staff, a Certified Nurse Aide (CNA)4 used profanity toward R51 during care. In addition, when R39 sat on R63's bed and pushed down on R63's chest with his hands. Failure to protect residents from abuse has the potential to result in injury to residents. Findings include: 1. Review of R51's"Admission Record" located in electronic medical record (EMR) under the "Profile" tab indicated R51 was admitted on 05/04/23 with diagnoses which included unspecified dementia, unspecified severity with agitation, and generalized anxiety. Review of the quarterly "Minimum Data Set" (MDS)" with an Assessment Reference Date (ARD) of 11/03/23, found in the EMR under the "MDS" tab indicated a "Brief Interview for Mental Status (BIMS)" score of five out of 15, indicating a severe cognitive deficit. Review of the "Investigation File," dated 01/19/24 indicated a written statement by Assistant Director of Nurses (ADON) 1 indicated he was informed that CNA2 witnessed CNA4, during resident care, using profanity toward R51. The	F 600	F600 Free from Abuse and Neglect CFR(s): 483.12(a)(1) 1. A. CNA2 promptly reported the event to nursing administration and CNA4 was immediately removed from resident care pending investigation and was subsequently terminated from employment. Upon interview R51 did not recall the event which is consistent with his cognitive impairment and continues to reside at the facility. B. All residents have the potential to be affected. All staff will receive re-training by Staff Educator, Michelle Turin, MSN, RN as of June 14, 2024, regarding abuse/neglect/mistreatment and the reporting of same as part of the investigative process. C. All staff receive periodic and at least annual training regarding abuse/neglect/mistreatment, the reporting of same, dementia training, as well as identifying staff burnout. Staff are provided access and information regarding Employee Assistance Program (EAP) and are encouraged to take advantage of the services offered. Trainings will consist of	

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F 600	Continued From page 2 statement indicated CNA4 was removed from the unit, asked to write a statement, questioned by ADON1, suspended, and terminated following investigation of the incident. Further review of the "Investigation File" indicated a "Root Cause Analysis" indicated the following: at approximately 6:00 AM on 01/19/24, staff (CNA2) witnessed another staff (CNA4) make inappropriate verbal remarks towards a resident (R51) during care. CNA4 stated that she became frustrated with the resident who was not being compliant with care and admitted that her tone was firm, and she may have used "profanity words under her breath." CNA2, who came in to assist with care, overheard CNA4 using words of profanity toward R51. Review of CNA2's written statement indicated that while she was helping CNA4 provide care to R51 on 01/19/24, CNA4 was becoming verbally aggressive to him. The statement indicated CNA told R51 he was "pissing her off." CNA2 said CNA4 wanted R51 to hold onto the sit to stand device, R51 was not being cooperative, and CNA4 told R51 to "hold onto the "fucking thing." CNA2 said CNA4 said, within earshot of R51. that he was "fucking annoying her." During an interview, by telephone, with CNA2 on 04/24/24 at 7:47 PM, CNA2 said she witnessed CNA4 using foul language with R51. She said they were providing care, and he was not being cooperative, and CNA4 got frustrated with him. CNA2 said CNA4 was using the words "fuck" and "fucking" toward R51. During an interview, by telephone, with CNA4 on 04/25/24 at 2:19 PM, she said she was assigned	F 600	the Abuse policy; Dementia training via Relias, this will include all staff and the new onboarding staff will add to this list for training compliance. Attachments are Abuse policy, Dementia manuscript, and signage sheet for the staff. D. Staff Educator, Michelle Turin, MSN, RN will complete a 100% audit to ensure all staff have received training on abuse/neglect/ mistreatment and the reporting of same as of June 14, 2024. Staff Educator, Michelle Turin, MSN, RN will report through QAPI process ongoing formal abuse/neglect/mistreatment training for all employees to ensure 100% compliance Monthly x 3 Quarterly x 2 and at least annually. 2. A. Staff intervened immediately upon hearing the event in progress and removed R39 from the area. R39 was immediately placed on continuous 1:1 supervision/observation and subsequently sent to a Psychiatric facility for further evaluation and treatment. R63 was unable to recall the event consistent with his cognitive impairment and continues to reside at the facility. B. All residents have the potential to be affected. All staff will receive re-training by Staff Educator, Michelle Turin, MSN, RN as of June 14, 2024, regarding abuse/neglect/mistreatment and the reporting of same as part of the investigative process. C. All staff receive periodic and at least annual training regarding	

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F 600	Continued From page 3 to R51's unit that evening and was already mad because she had been floating and working different units all the time. She said she was providing care to R51 and providing peri care. She said he kept trying to pull up his pants before she was done, and she said she might have gotten loud because he was not hearing her but denied using profanity or being able to recall using profanity. She said she was accused of using profanity towards R51. She said she was removed from the unit and facility and has not been back. Review of CNA4's "Personnel File" indicated she received training on Abuse, Neglect and Exploitation on 09/12/23, and Dementia Care with the "Hand in Hand" program on 09/13/23. During an interview, by telephone on 04/25/24 at 10:04 AM, Registered Nurse (RN) 4 said she did not recall anyone reporting this incident of abuse to her because she would have reported it to ADON1. She said CNA2 did tell her that CNA4 was not applying R51's ted stockings so she told her R51 needed to have them, it was ordered so it must be done. RN4 said CNA2 told her that CNA4 told R51 "you are making it hard for me to turn you or something," and had exhibited an "attitude" in general that night. During an interview on 04/25/24 at 9:39 AM, ADON1 said CNA2 reported that CNA4 became frustrated while providing care to R51 and used profanity toward R51. ADON1 said he interviewed staff that were on duty, removed CNA4 from the unit, asked her to write a statement, placed her on administrative leave and had her leave the facility. He said the abuse was substantiated and CNA4 was terminated. He said all staff were	F 600	abuse/neglect/mistreatment, the reporting of same, as well as dementia training. Trainings will consist of the Abuse policy; Dementia training via Relias, this will include all staff and the new onboarding staff will add to this list for training compliance. Attachments are Abuse policy, Dementia manuscript, and signage sheet for the staff. D. Staff Educator, Michelle Turin, MSN, RN will complete a 100% audit to ensure all staff have received training on abuse/neglect/ mistreatment, the reporting of same, as well as dementia training as of June 14, 2024. Staff Educator, Michelle Turin, MSN, RN will report through QAPI process ongoing formal abuse/neglect/mistreatment and dementia training for all employees to ensure 100% compliance Monthly x 3 Quarterly x 2 and at least annually.	

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F 600	Continued From page 4 re-trained related to abuse. ADON1 said R51 exhibited no behavior changes and did not recall the incident. Review of the Social Worker (SW)3's statement dated 01/19/24 indicated she spoke with R51 and when asked how his day was going, R51 stated it was going great because he had been able to sleep late. The statement indicated that when asked if anything unusual happened, R51 said no, and denied anyone yelling at him or speaking to him in a mean way. The statement indicated R51 did not appear upset. 2. Review of R39's "Admission Record" in the EMR under the "Profile" tab indicated R39 was admitted on 08/17/22 with diagnoses including Alzheimer's early onset, restlessness and agitation, major depressive disorder, and bipolar disorder. Review of R39's quarterly "MDS" with an ARD of 11/09/23 in the EMR under the "MDS" tab indicated a "BIMS score was four out of 15, indicating a severe cognitive deficit. Review of R39's "Care Plans" in the EMR under the "Care Plan" tab indicated care plans in place at the time of the incident included R39's behaviors: aggressiveness, towards others, hallucinations, delusions, easily agitated, tearful episodes, purposeful intentions of sitting self on the floor related to dementia included the following intervention: when resident becomes agitated with staff and other residents encourage resident to go for a walk off the unit. Review of R63's"Admission Record" in R63's EMR under the "Profile" tab indicated R63 was	F 600		

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F 600	Continued From page 5	F 600		

admitted on 11/21/23 with diagnoses including anxiety, neurocognitive disorder with Lewy bodies, and post-traumatic stress disorder (PTSD).

Review of the admission "MDS" with an ARD of 11/28/23 in the EMR under the "MDS" tab indicated the "BIMS" score was a six out of 15 indicating a severe cognitive deficit.

Review of R39's "Health Status Note," dated 01/23/2024 at 4:06 AM in the EMR under the "Progress Note" tab indicated staff heard a commotion and found R39 kneeling on R63's bed with one knee while his hands were around R63's crossed wrists, pressing against R63's chest. The "Health Status Note" indicated R63 remained lying in bed as if in shock, unable to defend himself. Staff removed R39 from the area and re-directed him.

During an interview on 04/24/24 at 4:34 PM, the Unit Manager (UM) 1 stated that R39 has periods when he is up at night, and it was not unusual for him to be in the hallway where R63's room was located.

During an interview on 04/25/24 at 9:41 AM, the ADON1 said R39 thought that it was his room and R63 was in his bed. ADON1 said R63 did not realize what was going on and R39 was removed and easily re-directed. ADON1 said R39 was placed on 1:1 supervision and transferred to an inpatient psychiatric facility on 01/26/24.

The "Investigation File" indicated that when R39 was asked what he was doing, he stated that R63 was in his bed.

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F 600	Continued From page 6 Review of the facility's policy titled "Abuse and Neglect" dated 12/03/20 and recently revised on 04/04/24 indicated incidents of abuse will be investigated, reported, facility staff will be educated and trained, and incidents could be cause for immediate termination.	F 600		
F 623 SS=E	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would	F 623		5/17/24

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F 623	Continued From page 7	F 623		

be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental

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F 623	Continued From page 8 disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on interview, record review, and policy review, the facility failed to ensure resident, and resident's representatives were notified at time of discharge of the location and reason for the discharge for a sample of four of four residents (Resident (R)13, R19. R12 and R39) reviewed for hospitalization. As a result of this deficient practice, residents had the potential for location of residents not known to families or resident representatives. Findings include:	F 623	F623 Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) 1. A. R13'S Bed Hold letters for the dates cited did not contain information as to reason for or location of transfer in writing. Per R13's progress notes of 12/3/23 at approximately 1405 POA was made aware of residents change in condition and transfer to hospital. Per R13's progress notes of 12/17/23 at	

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F 623	Continued From page 9 1. Review of R13's "Admission Record" located in the electronic medical record (EMR) under the "Profile" tab, revealed an admission date of 04/26/22 and readmission on 12/21/23 with medical diagnoses that included chronic obstructive pulmonary disease and adult failure to thrive. Review of R13's Significant Change "Minimum Data Set (MDS)" located in the EMR under the "MDS" tab with an Assessment Reference Date (ARD) of 01/17/24, revealed a "Brief Interview for Mental Status (BIMS)" score of 3 out of 15, indicating R13 was severely cognitively impaired. Review of the "Misc" tab in the EMR revealed a bed hold agreements dated 12/02/23 and 12/17/23 as date of transfer and lacked information about the reason or destination of the transfer of the resident. Review of the "Progress Notes" tab in the EMR documented Social Services entry on 12/04/23 and 12/18/23 revealed "Note Text: Bed hold notice to Ombudsman/MCO/Family/POA [Power of Attorney] and lacked documentation of where the resident was transferred to or why transfer was needed, 2. Review of R19's undated "Admission Record," located in the "Profile" tab of the EMR revealed R19 was initially admitted to the facility on 09/12/23 with diagnoses of chronic kidney disease, stage 3, diabetes mellitus, essential hypertension, and hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side. Review of a quarterly "MDS" located in the EMR	F 623	approximately 1541 POA was made aware of residents change in condition and POA was present during transfer to hospital. The facility is unable to correct after the time of discharge, however, R13 suffered no untoward effect regarding the deficient practice. B. All residents have the potential to be affected. The Bed Hold Letter was amended during the survey by the Director of Nursing to reflect reason for transfer as well as location of transfer so that no other resident will be further affected by the deficient practice. C. All licensed staff will be re- in serviced by Staff Educator, Michelle Turin, MSN, RN as of June 14, 2024, regarding updated Bed Hold Letter reflecting reason for transfer and location of transfer. Training will consist of the bed hold policy and the revised bed hold letter. This will include clinical staff, social workers, and all new onboarding clinical staff. Attachments are the bed hold policy, the revised bed hold document, and the audit sheet that will be completed by social services. D. Admissions Director, Sandra Redick, LCSW will audit Bed Hold Letters for those transferred from facility daily x 30 then weekly x 4 then monthly x 1 until 100% compliance is achieved. Results will be reported through QAPI process. 2. A. R19'S Bed Hold letters for the date cited did not contain information as to reason for or location of transfer in writing. Per R19's progress notes of 3/4/24 at approximately 1900 POA was made	

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F 623	Continued From page 10 under the "MDS" tab, with an ARD of 01/21/24 indicated R19 had a "BIMS" score of 10 out of 15 which indicated R19 was moderately cognitively impaired. Review of a document titled "DVH Bed Hold Notice at Time of Transfer" dated 03/06/24, located in the EMR under the "Misc" tab, revealed R19's representative received a bed hold notice upon R19's transfer. The document did not indicate where R19 was transferred too. Review of R19's "Social Services progress notes" located in the EMR under the "Progress Notes" tab, dated 03/05/24 indicated social services had sent a bed hold notice to R19's power of attorney (POA). Review of a "Social Services progress note" dated 03/06/24 indicated the facility had received a signed bed hold notice from R19's POA. Neither note indicated the POA had received written notice of the location of R19's transfer. Review of a document titled "DVH Bed Hold Notice at Time of Transfer" dated 04/23/24, located in the EMR under the "Misc" tab, revealed R19's representative received a bed hold notice upon R19's transfer. The document did not reveal where R19 was transferred too. Review of R19's "Social Services progress notes" located in the EMR under the "Progress Notes" tab, dated 04/23/24 indicated social services had sent a bed hold notice to R19's POA. The note did not indicate the POA had received written notice of the location of R19's transfer. 3. Review of R12's "Admission Record," located in the EMR under the "Profile" tab revealed R12	F 623	aware of change in condition as well as destination via telephone. The facility is unable to correct after the time of discharge, however, R19 suffered no untoward effect regarding the deficient practice. B. All residents have the potential to be affected. The Bed Hold Letter was amended during the survey by the Director of Nursing to reflect reason for transfer as well as location of transfer so that no other resident will be further affected by the deficient practice. C. All licensed staff will be re- in serviced by Staff Educator, Michelle Turin, MSN, RN as of June 14, 2024, regarding updated Bed Hold Letter reflecting reason for transfer and location of transfer. Training will consist of the bed hold policy and the revised bed hold letter. This will include clinical staff, social workers, and all new onboarding clinical staff. Attachments are the bed hold policy, the revised bed hold document, and the audit sheet that will be completed by social services. D. Admissions Director Sandra Redick, LCSW will audit Bed Hold Letters for those transferred from facility daily x 30 then weekly x 4 then monthly x 1 until 100% compliance is achieved. Results will be reported through QAPI process. 3. A. R12'S Bed Hold letters for the date cited did not contain information as to reason for or location of transfer in writing. Per R12's progress notes of 11/30/23 at	

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F 623	Continued From page 11 was initially admitted on 11/19/18 and most recently readmitted on 04/13/24 with diagnoses that included chronic atrial fibrillation, asthma, atherosclerotic heart disease of natural coronary artery without angina pectoris, and retention of urine. Review of the quarterly "MDS" with an ARD of 02/27/24 revealed a "BIMS" score of nine out of 15 indicating R12 was moderately cognitively impaired. Review of the "Census" located in the EMR under the "Clinical" tab revealed R12 was hospitalized from 11/30/23 to 12/13/23. Review of the "Progress Notes" located in the EMR under the "Clinical" tab revealed no written evidence a Bed Hold notification with the location or reason for the transfer/discharge was provided to the resident and resident's representative for the two identified hospitalizations. 4. Review of the "Admission Record," found in R39's EMR under the "Profile" tab indicated R39 was admitted on 08/17/22. The "Admission Record" indicated diagnoses included Alzheimer's disease, depression, restlessness and agitation, and bipolar disorder. Review of the "MDS" with an ARD of 11/09/23, found in R39's EMR under the "MDS" tab indicated R39's "BIMS" score was four out of 15, indicating a severe cognitive deficit. Review of the "Health Status Note," found in R39's EMR under the "Progress Notes" tab, dated 01/23/24 at 4:06 AM indicated R39 was seen "physically aggressing" another resident	F 623	approximately 0755 POA was made aware of change of condition and transfer to BayHealth Sussex Campus ED for evaluation via telephone. The facility is unable to correct after the time of discharge, however, R12 suffered no untoward effect regarding the deficient practice. B. All residents have the potential to be affected. The Bed Hold Letter was amended during the survey by the Director of Nursing to reflect reason for transfer as well as location of transfer so that no other resident will be further affected by the deficient practice. C. All licensed staff will be re- in serviced by Staff Educator, Michelle Turin, MSN, RN as of June 14, 2024, regarding updated Bed Hold Letter reflecting reason for transfer and location of transfer. Training will consist of the bed hold policy and the revised bed hold letter. This will include clinical staff, social workers, and all new onboarding clinical staff. Attachments are the bed hold policy, the revised bed hold document, and the audit sheet that will be completed by social services. D. Admissions Director Sandra Redick, LCSW will audit Bed Hold Letters for those transferred from facility daily x 30 then weekly x 4 then monthly x 1 until 100% compliance is achieved. Results will be reported through QAPI process. 4. A. R39'S Bed Hold letters for the dates cited did not contain information as to reason for or location of transfer in writing. R39's POA was present prior to and	

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F 623	Continued From page 12 while that resident was in bed asleep. The "Health Status Note" indicated R39 was discovered kneeling on the other resident's bed with one knee while his hands were around the other resident's crossed wrists, pressing against the chest of the other resident. Review of R39's "Health Status Note," found in the EMR under the "Progress Notes" tab, dated 01/26/24 at 3:04 PM indicated R39 left the facility, accompanied by a unit manager, and was transported to Meadowood (an inpatient psychiatric facility). Review of R39's"Social Service" note found in EMR under the "Progress Notes" tab, dated 01/29/24 at 3:00 PM indicated the "Bed-hold Notice at Time of Transfer" was sent to the Responsible Party. Review of R39's"Bed-Hold Notice at Time of Transfer," found in the EMR, under the "Misc" tab dated 01/26/24, indicated the "Bed-Hold Notice at Time of Transfer," did not include the name of the facility that he was being transferred to and did not include in writing the reason for the transfer/discharge. During an interview on 04/24/24 at 2:26 PM, the Social Work Consultant (SW2) explained the process was to notify family or resident representative within 24 hours with the bed hold information. A note was made in the EMR progress note to indicate the notification was made and the bed hold information was mailed out. During an interview on 04/25/24 at 10:44 AM, the Administrator confirmed the bed hold information	F 623	during the transfer to the facility for the event cited on 1/26/24. The POA, UM, and DON discussed at length the possible destination for R39, and the decision was made to transfer the resident to the facility cited. R39 was transferred accompanied by the UM to the facility cited as specifically agreed upon by the POA, UM, and DON. The facility is unable to correct after the time of discharge, however, R39 suffered no untoward effect regarding the deficient practice. B. All residents have the potential to be affected. The Bed Hold Letter was amended during the survey by the Director of Nursing to reflect reason for transfer as well as location of transfer so that no other resident will be further affected by the deficient practice. C. All licensed staff will be re- in serviced by Staff Educator, Michelle Turin, MSN, RN as of June 14, 2024, regarding updated Bed Hold Letter reflecting reason for transfer and location of transfer. Training will consist of the bed hold policy and the revised bed hold letter. This will include clinical staff, social workers, and the new onboarding staff will receive training during orientation for compliance. Attachments are the bed hold policy, the revised bed hold document, and the audit sheet that will be completed by social services. D. Admissions Director Sandra Redick, LCSW will audit Bed Hold Letters for those transferred from facility daily x 30 then weekly x 4 then monthly x 1 until 100% compliance is achieved. Results will be reported through QAPI process.	

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F 623	Continued From page 13 sent out to the resident or resident's representatives lacked information about the reason or location where the resident was discharged to and confirmed the information was missing on the form sent to the resident or resident's representative. Review of the facility policy titled "Bed Hold Policy" dated 01/04/24 revealed, "At the time of transfer for hospitalization or therapeutic leave, the facility will provide to the resident and/or the resident representative written notice which specifies the duration of the bed-hold policy and addresses information explaining the return of the resident to the next available bed." When a Transfer/Discharge policy was requested, the Bed Hold Policy was provided and lacked information about the reason or location of the transfer of the resident to be provided to the family or resident representative.	F 623		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying,	F 880		5/17/24

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F 880	Continued From page 14 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 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	F 880		

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F 880	Continued From page 15 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 observation, interviews, record review, policy and procedure review, the facility failed to follow infection control procedures during a dressing change for one of three residents (R)4 reviewed. Specifically, the Registered Nurse (RN)1 failed to clean the over the bed table or place a barrier on the table before placing clean wound supplies on the table. Also, RN1 failed to perform hand hygiene when she returned to the room after obtaining a dressing from the treatment cart. The failure created the potential for an infection to develop in R4's wounds. Findings include: Review of the facility's policy titled "Skin Integrity/Wound Care" dated 03/08/23, revealed " ... ...A resident with skin impairment will receive treatment and services, consistent with professional standards of practice, to promote healing ..." Review of the facility's procedure titled "Wound Treatment Competency Audit" provided by the Administrator on 04/25/24 revealed the following criteria for all nurses to utilize ...7. Assembles necessary equipment &[and] places on clean,	F 880	F880 Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) 1. R4's wounds were re-evaluated after the event on 4/24/24 and appropriate dressing change per standard of care was completed. R4's wound has been tracked since the event with noted improvement and no evidence of infection. The facility is unable to correct the deficient practice after the event occurred. Upon interview by facility LNHA and DON, RN1 stated that she was nervous during the observation and failed to follow standards of care. RN1 was immediately provided education by Staff Educator Michelle Turin, MSN, RN, and competency on wound care until 100% return demonstration was achieved. 2. All residents have the potential to be affected by the deficient practice. 3. All Licensed staff will be in serviced by Staff Educator Michelle Turin, MSN, RN regarding infection control and prevention standards of care to include	

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F 880	Continued From page 16 accessible surface 8. Places date, time, and initials on dressing. 9. Hand hygiene performed prior to and after the treatment of each wound ... 10. Puts on gloves ... 12. Soiled dressing gently removed & placed in a small waste bag. 13. Removes gloves and places in trash receptacle 14. Hand hygiene I 5. Prepares dressing, without contamination 16. Hand hygiene, put on clean gloves and cleanse site 17. Applies treatment as ordered ...21. Hand hygiene prior to returning equipment to cart ...STEPS MUST BE FOLLOWED FOR THE TREATMENT OF EACH WOUND" Review of R4's "Admission Record," located in the electronic medical record (EMR) under the "Profile" tab revealed R4 was admitted on 01/30/20 with diagnoses that included chronic atrial fibrillation, unspecified cardiovascular and coagulations; post-traumatic stress disorder, chronic; idiopathic progressive neuropathy, and acute neurologic. Review of the quarterly "Minimum Data Set (MDS)" assessment with an assessment reference date of (ARD) of 04/03/24 revealed a "Brief Interview for Mental Status (BIMS)" score of 99 indicating R4 was unable to participate in the assessment due to severe cognitive impairment. Review of the "Progress Notes" located in the EMR under the "Clinical" tab revealed R4 was identified to have two open areas on 04/16/23 which indicated, "Nurse notified by aid in reference to two open areas noted behind resident's left knee with measurements of 5.5 centimeters (cm) x 1.3 cm and 1.0 cm x 1.0 cm ..."	F 880	competencies with return demonstration of hand hygiene and proper preparation to complete wound care as of June 14, 2024. Training will consist of education on the infection prevention & control program and the skin integrity/wound care policy. All clinical staff will be trained, and the new onboarding staff will receive training during orientation for compliance. Attachments consists of the infection prevention and wound care policy, signage sheet for staff, and a wound treatment competency to utilize during training. 4. Each Unit Manager or Assigned Supervisor will observe wound care for current wounds daily x 7, weekly x 3, monthly x 2, to ensure infection control and prevention standards of care are followed until and be reported through QAPI until 100% compliance is achieved.	

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F 880	Continued From page 17 Review of the "Physician's Orders" dated 04/18/24, located under the "Clinical" tab in the EMR, revealed a treatment order for "wound care left posterior knee: cleanse with Normal Saline Solution (NSS), pat dry. Apply calcium alginate and cover with ...dry dressing as needed." On 04/24/24 at 9:13 AM, RN1 was observed to perform R4's dressing change to the left posterior knee. RN1 obtained the required materials from the treatment cart and proceeded to R4's room. RN1 placed the items on an overbed table and performed hand hygiene. RN1 did not clean the table or place a clean covering over the table before placing the items on the table. RN1 performed hand hygiene, donned gloves and removed the dressing from the resident's left posterior knee. RN1 doffed the gloves, donned clean gloves and cleaned the wounds with a sterile saline wipe. RN1 dropped the calcium alginate dressing in the trash, left the room to retrieve another calcium alginate from the treatment cart located down the hall from R4's room. RN1 returned to R4's room, without performing hand hygiene donned a new pair of gloves, placed the calcium alginate on the left posterior knee and then a dry dressing. During an interview with RN1 and Unit Manager (UM2) on 04/24/24 at 10:35 AM, RN1 confirmed that she did not perform hand hygiene when she returned to the room after obtaining a calcium alginate from the treatment cart before donning a clean pair of gloves. RN1 confirmed that she did not date the dressing per facility protocol. UM2 stated, "the expectation would be to clean the overbed table and wash hands again when returning to the room."	F 880		

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F 880	Continued From page 18 In an interview on 04/25/24 at 10:28 AM, the Administrator stated, "I retrained everyone on handwashing on 04/24/24 and I personally retrained RN1 on wound care criteria as well."	F 880		