DELAWARE HEALTH AND SOCIAL SERVICES

Division of Health Care Quality
Office of Long Term Care Residents Protection

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

STATE SURVEY REPORT

NAME OF FACILITY: Delaware Veterans Home

DATE SURVEY COMPLETED: September 10, 2021

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 survey was conducted at this facility from September 2, 2021 to September 10, 2021. The deficiencies contained in this report are based on observation, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census on the first day of the survey was 50. The survey sample totaled 29 residents.		
	In accordance with 42 CFR 483.73, an Emergency Preparedness survey was also conducted by The Division of Health Care Quality, the Office of Long-Term Care Residents Protection at this facility during the same time period.		
	For the Emergency Preparedness survey, deficiencies were cited.		
16 Del.	**Health and Safety Delaware Administrative Code**		
3201	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.0	**Scope**		
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby**		

Provider's Signature Carol [signature] Title Administrator Date 10/4/21

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	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 September 10, 2021: F554, F641, F655, F656, F676, F684, F685, F689, F755, F756, F758, F761, F790, F812 and F943.		
16 Del.C.	**Health and Safety**		
Chapter 11	**Regulatory Provisions Concerning Public Health**		
§ 1144	**Long Term Care Facilities and Services**		
	Influenza Immunizations **(a) Nursing and assisted living facilities shall annually offer, beginning no later than October 1st through March 1st of a calendar year, onsite vaccinations for influenza vaccine to all employees with direct contact with patients at no cost and contingent upon availability of the vaccine.** **(b) The facility shall keep on record a signed statement from each employee stating that the employee has been offered vaccination against influenza and has either accepted or declined such vaccination.**		
	This requirement is not met as evidenced by:		
	Based on interview and review of other facility documentation it was determined that, for four (E18, E20, E21 and E26) out of 14		

Provider's Signature [signature] Title LNHA Date 10/4/21

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	sampled employees, the facility failed to provide evidence of influenza vaccination or declination for the prior flu season. Findings include: Review of a facility-completed spreadsheet and influenza information revealed the following staff members lacked an influenza vaccination or declination during the 2020-2021 flu season: E18 (CNA), E20 (CNA), E21 (CNA) and E26 (OT). 9/9/21 approximately 3:00 PM – The lack of influenza acceptance or declination was reviewed with E2 (DON). Findings were reviewed with E1 (NHA), E2, and E3 (Deputy Director) during the Exit Conference on 9/10/21 at approximately 3:15 PM.		
§ 1162	**Nursing Staffing** **(a) ... Every residential health facility must at all times provide a staffing level adequate to meet the care needs of each resident, 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**		

Provider's Signature [signature] Title LNHA Date 10/4/21

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	through temporary agencies shall be required to wear photo identification listing their names and titles. **This requirement is NOT MET as evidenced by:** Based on observation and interview, it was determined that the facility failed to conspicuously display in common areas of one (Red) of the two nursing units, the name of the nursing supervisor on duty for each shift. Findings include: 9/7/21 3:00 PM – A random observation of the Red unit's common areas revealed that the required current staffing information was not posted in a location visible to residents and was missing the name of the supervisor on duty. The staffing information was on a bulletin board behind the nurses' station, next to the unit secretary's desk. 9/7/21 3:15 PM – During an interview, E9 (RN, UM) confirmed the above finding and moved the posting to a bulletin board that was visible to residents. 9/9/21 9:00 AM - During another random observation on the Red unit, the required staffing information was again not visible to residents. It was on a bulletin board behind the nurses' station, next to the unit secretary's desk and was missing the name of the supervisor on duty. 9/9/21 9:15 AM - During an interview, E4 (ADON) confirmed the above finding and stated he will correct and move the posting to a spot that was visible to residents.		

Provider's Signature Carol Elliott [signature] Title LNHA Date 10/4/21

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	Findings were reviewed with E1 (NHA), E2 (DON) and E3 (Deputy Director) during the Exit Conference on 9/10/21 at approximately 3:15 PM.		

Provider's Signature Carol E Knost [signature] Title LNHA Date 10/30/21

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	085051	A. BUILDING ______ B. WING ______	C 09/10/2021

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E 000	Initial Comments An unannounced annual and complaint survey was conducted at this facility from September 2, 2021 through September 10, 2021. The facility census was 50 on the first day of the survey. In accordance with 42 CFR 483.73, an Emergency Preparedness survey was also conducted by The Division of Health Care Quality, the Office of Long-Term Care Residents Protection at the facility during the same time period. For the Emergency Preparedness survey, deficiencies were cited.	E 000		
E 037 SS=E	EP Training Program CFR(s): 483.73(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency	E 037		10/31/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE: — (X6) DATE: 10/04/2021

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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E 037	Continued From page 1 procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency	E 037		

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E 037	Continued From page 2 preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at	E 037		

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E 037	Continued From page 3 least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff,	E 037		

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E 037	Continued From page 4 individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This REQUIREMENT is not met as evidenced by: Based on review of facility documentation and interview it was determined that for fourteen (E9, E17, E18, E19, E20, E21, E22, E23, E24, E25, E26, E27, E28 and E29) out of fourteen sampled staff members, the facility failed to ensure that staff received annual emergency preparedness training in the previous twelve months. Findings include: Review of a facility-completed spreadsheet entitled Staff Training and Vaccination and training records revealed the latest training dates on emergency preparedness:	E 037	1. Based on record review and interview it was determined that the facility failed to ensure that staff received annual emergency preparedness training in the previous twelve months. Education will be provided by staff education on emergency preparedness for the following staff: E9, E17, E18, E19, E20, E21, E22, E23, E24, E25, E26, E27, E28 and E29. 2. All employees in the facility have the	

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E 037	Continued From page 5 - 1/20/20: E17 (CNA). - 3/25/20: E18 (CNA). - 6/13/20: E23 (RN). - 6/15/20: E9 (RN), E28 (Grounds) and E29 (Volunteer Services). - 6/16/20: E19 (CNA), E20 (CNA) and E27 (Activities). - 6/17/20: E21 (CNA), E24 (RN) and E25 (LPN). - 7/1/20: E26 (OT). - None in 2020 or 2021: E22 (LPN). 9/9/21 2:47 PM - The lack of education in the past year was reviewed with E2 (DON). 9/10/21 8:10 AM - Review of additional documents provided by the facility resulted in no additional education records. Findings were reviewed with E1 (NHA), E2 and E3 (Deputy Director) during the Exit Conference on 9/10/21 at approximately 3:15 PM.	E 037	potential to be affected by this deficient practice and will receive annual training on emergency preparedness. All employees education plan records were reviewed. It was determined that the facility new hire orientation and annual education provided education for emergency codes, but did not provide education for emergency preparedness. All staff members were impacted and emergency preparedness plan was created. Staff educator will educate all current staff by October 31st. Staff Educators will also provide this Emergency Preparedness Training to all future employees with new employee orientation and all staff annually. 3. RCA: Lack of systemic tracking system of education courses. Administrator will educate the Administrative Nursing Team to the requirement for annual Emergency Preparedness. Then the Staff Educators will train the employees on emergency preparedness and ensure completion of training by all employees. Staff Educators will develop a new tracking system to identify staff completion of annual training, to include emergency preparedness training. Emergency Preparedness(EP) was added to the current education plan (see attached). The new tracking program was created by Staff Educator(s) on an Excel Spreadsheet. This spreadsheet includes the name of all staff members and the	

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E 037	Continued From page 6	E 037	date EP was completed. Staff Educator(s) will review at the beginning of each month to determine which staff members are due and notify those staff members to ensure completion. The policy was updated to add E037 was added to Related Regulations. Emergency Preparedness to annual education and that education will be by calendar year. 4. Emergency Preparedness education will be completed for all current staff by October 31,2021 as per the plan of correction date certain. For Year 2022 and moving forward, the Regulatory Specialist (or designee) will conduct monthly audits to ensure that 100% compliance is achieved. Non-compliance will be reported to the Administrator in November and December. If 100% compliance is achieved, the deficiency will be considered resolved. Results of the audit will be presented and discussed at the monthly facility QAPI meeting.	
F 000	INITIAL COMMENTS An unannounced annual, complaint and emergency preparedness surveys were conducted at this facility from September 2, 2021 through September 10, 2021. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census on the first day of the survey was 50. The sample size was 29. Abbreviations and Definitions used in this report are as follows:	F 000		

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F 000	Continued From page 7 ADON - Assistant Director of Nursing; CNA - Certified Nurse's Aide; DON - Director of Nursing; FM - Family member; LPN - Licensed Practical Nurse; MD - Medical Doctor; NHA - Nursing Home Administrator; NP- Nurse Practitioner; POA - Power of Attorney; RN - Registered Nurse; RNAC - Registered Nurse Assessment Coordinator; SW - Social Worker; QA - Quality Assurance; UM - Unit Manager. BIMS (Brief Interview for Mental Status) - test to measure thinking ability with score ranges from 00 to 15: 13-15 - cognitively intact. 8-12 - moderately impaired. 0-7 - severe impairment; MDS (Minimum Data Set) - standardized assessment forms used in nursing homes; MASD - Moisture-associated skin damage; Dementia - A chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning; TAR (Treatment Administration Record) - list of resident treatments that are signed off when completed.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer	F 554		10/31/21

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F 554	Continued From page 8 medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that for one (R45) out of six residents reviewed for medications the facility failed to assess the ability to self-administer a medication when requested by a resident. Findings include: Cross refer F655 7/21/15 (date of last revision) - The facility's Self-Administration of Medications policy included "If a resident requests to self-administer drugs, the interdisciplinary team will determine if it is safe for that resident to do so before the resident may exercise that right." Review of R45's clinical record revealed the following: 4/28/21 - R45 was admitted to the facility with heart disease and several psychiatric disorders. 4/28/21 - An order was written for R45 to receive nitroglycerin under his tongue every five minutes as needed for angina or chest pain and to notify medical staff if no relief after three doses. 5/4/21 - An Admission MDS (Minimum Data Set) Assessment documented that R45 had BIMS of 15 (cognitively intact). 7/30/21 - A Quarterly MDS Assessment documented that R45 had BIMS of 15 (cognitively intact).	F 554	1. Based on observation, interview, and record review, it was determined that the facility failed to assess the ability to self-administer a medication when requested by a resident. There is no correct action for this resident as this medication for R45 had been discontinued. 2. All residents have the potential to be affected. The facility did an audit of the past 30 days and determined that no other residents made a request to self-administer medications. Residents will be asked during the Interdisciplinary Care Conference (IDCC) if they have any concerns and or requests. All requests for self-administration of medications will be assessed with the self-administration assessment tool and follow-up with IDT. 3. RCA: Facility failed to follow the self-administration medication policy. Staff Educators (or designee) will educate Licensed Staff on the Self Administration Policy. All requests to self-administration medications at this time will be assessed with the self-administration assessment tool, then discussed with the IDT. Documentation of IDT's evaluation and decision will be documented in the resident's clinical record.	

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F 554	Continued From page 9 8/6/21 - A Significant Change MDS Assessment documented that R45 had BIMS of 15 (cognitively intact). 9/2/21 4:50 PM - During an interview, R45 stated, "I asked to have my nitroglycerin in my room so I can take it right away when I need it. I can feel it when my blood pressure goes up. If I put on my call bell, I have to wait 15 minutes for someone to answer. I could be dead by then. I would have died if I did not have my nitroglycerin to take when I had my last heart attack a year or so ago. I don't want to die. I told [E4, ADON] I want my nitroglycerin in my room, and he said I would not have another heart attack because of the blood pressure medicines I'm on. I don't know if I even have nitroglycerin ordered. I don't know what the hell they are giving me." 9/7/21 12:30 PM - During an interview, E2 (DON) provided a copy of the facility's Self-Administration of Medications policy and stated she would look for any documentation that the interdisciplinary team evaluated E45 after his request to self-administer nitroglycerin. 9/7/21 3:15 PM - During an interview, E9 (RN, UM) stated that R45 would not be safe to have nitroglycerin in his room because of his upper extremity tremors and his blood pressure has been low at times, but there is no documentation that the interdisciplinary team evaluated him after his request to self-administer nitroglycerin. Findings were reviewed with E1 (NHA), E2 (DON) and E3 (Deputy Director) during the Exit Conference on 9/10/21 at approximately 3:15 PM.	F 554	4. After providing them education and also checking the clinical records to ensure documentation is completed by the nurse and evaluated by IDT, the QA nurse (or designee) will conduct monthly audits of random nursing staff sampling (25%) on knowledge of the P&P. The QA nurse (or designee) will conduct monthly audits of the IDCC meetings to ensure the policy is followed. Findings of the audits will continue to be reported to the QAPI committee monthly until 100% compliance is reached. The results of the audits will be reported and reviewed at QAPI.	

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F 641	Continued From page 10	F 641		
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to ensure the accuracy of Minimum Data Set (MDS) assessments for five (5) out of 29 sampled residents in the areas of skin conditions (R41, R45, R47 and R48) and restraints/alarms (R35). Findings include: 1. Review of R41's clinical records revealed the following: 8/6/21 - Quarterly MDS (Minimum Data Set) assessment documented the presence of MASD (Moisture Associated Skin Damage). 7/1/21 - 8/30/21 - Review of R41's nurse skin assessments revealed no skin problems or lesions present. 9/10/21 at 9:00 AM - During an interview, E2 (DON) confirmed that R41 did not have MASD and that the MDS will be corrected. 2. Review of R47's clinical records revealed the following: 8/13/21 - Quarterly MDS (Minimum Data Set) assessment documented the presence of MASD (Moisture Associated Skin Damage). 7/1/21 - 8/30/21 - Review of R47's weekly skin	F 641	1. Based on record review and interview it was determined that the facility failed to code M1040H and P0200E of the MDS accurately. The RNAC completed corrections to coding of MDS sections M1040H and P0200E of the MDS by September 16, 2021 for the following residents: R41, R45, R47, R48 and R35. 2. All Residents in the building could have been affected by this MDS coding error of M1040H and P0200E. A focus review of all current residents MDS□s for M1040H and P0200E was completed by and corrections to the additional MDS□s were made by September 17, 2021. 3. RCA: A focused review revealed a need for review of the RAI manual for M1040H and P0200E with the RNAC. Education to the RNAC was provided by the ADON on September 8, 2021 and September 10,2021. 4. The ADON (or designee) will audit questions M1040H and P0200E of MDS□s Ready for Export. The audit will be conducted weekly until 100% compliance is achieved for three consecutive audits. Then the ADON will	10/31/21

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F 641	Continued From page 11 assessments revealed no skin problems, tears/breaks, or lesions observed. 9/10/21 at 9:00 AM - During an interview, E2 (DON) confirmed that R47 did not have MASD and that the MDS will be corrected. 3. Review of R45's clinical records revealed the following: 5/4/21 - A Comprehensive Admission MDS (Minimum Data Set) assessment documented the presence of MASD (Moisture Associated Skin Damage). 4/28/21 - 5/25/21 - Review of R45's nurse skin assessments revealed no skin problems or lesions, except scattered moles. 9/10/21 at 9:00 AM - During an interview, E2 (DON) confirmed that R45 did not have MASD and that the MDS will be corrected. 4. Review of R48's clinical records revealed the following: 5/14/21 - A quarterly MDS assessment documented the presence of MASD (Moisture Associated Skin Damage). June 2021 - 8/25/21 - Review of R48's weekly skin assessments revealed no new skin issues noted and intact skin (no sores). 8/13/21 - A significant change MDS assessment documented that R48 had MASD. 9/10/21 at 8:43 AM - An interview with E2 (DON) confirmed that R48 did not have MASD and the	F 641	conduct audits of M1040H and P0200E for 10% of MDS□s Ready for Export monthly until 100% compliance is achieved for three consecutive audits. Results of the audit will be presented and discussed at the monthly facility QAPI meeting.	

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F 641	Continued From page 12 MDS would be corrected. 9/10/21 at 10:40 AM - In an interview, E7 (RNAC) confirmed the inaccurate MASD coding on the MDS assessment. 5. Review of R35's clinical records revealed the following: 4/20/21 - R35 was admitted to the facility with diagnoses including dementia with behaviors. 5/4/21 - A care plan was developed for R35's potential for elopement with interventions including to monitor placement of the wanderguard (small electronic device that triggers an alarm when close to sensors at the exit doors). 5/4/21 - A physician order included to check placement of the wanderguard on the resident's left wrist and to assess skin on the left wrist for redness or irritation every shift. 7/1/21 - 9/8/21 - R35's Treatment Administration Record revealed that nursing staff documented the placement of R35's wanderguard on his left wrist every shift. 7/16/21 - R35's quarterly MDS assessment documented that a wanderguard was not used. 9/2/21 - 9/8/21 at varying times - R35 was observed wearing a wanderguard on his left wrist. 9/8/21 at 9:08 AM - Interview with E2 (DON) confirmed that R35 wore a wanderguard on his wrist and that the MDS would be corrected.	F 641		

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F 641	Continued From page 13 9/10/21 at 10:45 AM - Findings of the inaccurate alarm coding was discussed and confirmed by E7 (RNAC). Findings were reviewed with E1 (NHA), E2 (DON) and E3 (Deputy Director) during the Exit Conference on 9/10/21 at approximately 3:15 PM.	F 641		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of	F 655		10/31/21

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F 655	Continued From page 14 this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R45) out of one resident reviewed for baseline care planning the facility failed to provide the medication list to the resident. Findings include: Cross refer F554 5/20/19 (date of last revision) - The facility's Care Plan Development, Implementation and Timing policy included, "[the facility] must provide the resident and the responsible party, if applicable, with a written summary of the baseline care plan ...no more than 21 days after admission ...The summary must include: a. Initial goals for the resident; b. A list of current medications and dietary instructions, and c. Services and treatments to be administered by the facility ...the medical record must contain evidence that the summary was given to the resident ...".	F 655	1. Based on record review and interview it was determined that the facility failed to provide and document a list of current medications to R45 within 48 hours of admission. Unit Manager provided resident R45 a list of his medications on September 9, 2021. 2. All Residents admitted to the facility have the potential to be impacted by this deficient practice. Social Services Administrator or designee will conduct a review of all residents admitted within the last 30 days and ensure resident and resident representative were provided a list of medications. 3. RCA: A focused review shows there was no system in place to ensure resident and resident representative received medication list within 48 hours of admission. The Administrator (or designee) will	

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F 655	Continued From page 15 Review of R45's clinical record revealed the following: 4/28/21 - R45 was admitted to the facility with heart disease and several psychiatric disorders. 5/4/21 - An Admission MDS (Minimum Data Set) Assessment documented that R45 had BIMS of 15 (cognitively intact). 5/11/21 2:19 PM - E11 (SW) documented a note that R45's initial care plan meeting from admission was held and E45 was present. 9/2/21 4:50 PM - During an interview, R45 stated, "I don't know if I even have nitroglycerin ordered. I don't know what the hell they are giving me." When asked if he received a copy of a list of his medicines, R45 said "No." 9/10/21 8:15 AM - During an interview, E11 (SW) stated after E45's baseline care plan meeting she gave him a copy of his care plan, but not his medication list. When asked if she normally gives residents / representative party a copy of their medication list she said, "No. Just a copy of the care plan." A baseline plan of care was developed and implemented. However, the clinical record lacked evidence that the baseline plan of care summary included that R45's medication list was provided to him. Findings were reviewed with E1 (NHA), E2 (DON) and E3 (Deputy Director) during the Exit Conference on 9/10/21 at approximately 3:15 PM.	F 655	educate Social Services on providing a list of medications within 48 hours of admission. The policy and education have been updated to include provide summary of baseline care plan and medication list within 48 hours of admission. 4. The Social Services Administrator (or designee) will audit the chart for documentation that a list of medications was provide to the resident/ representative within 48 hours of admission. The audit will be conducted weekly until 100% compliance is achieved for three consecutive audits. Then monthly until 100% compliance is achieved for three consecutive audits. Results of the audit will be presented and discussed at the monthly facility QAPI meeting.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan	F 656		10/31/21

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F 656	Continued From page 16 CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.	F 656		

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F 656	Continued From page 17 (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that for one (R28) out of 29 sampled residents the facility failed to develop a comprehensive care plan for the communication needs of a hearing aid, including it's use and care. Findings include: Cross Refer F676 1. The following was reviewed in R28's clinical record: 6/20/19 - R28 was admitted to the facility with dementia. 6/20/19 - A care plan, last updated 9/2/21, for Impaired Communication lacked evidence of the use and care of R28's hearing aids. 3/18/20 - The Treatment Administration Record included a task to clean the hearing aid and change the battery weekly. This was last signed off as completed on 9/2/21. 6/22/21 - The annual MDS assessment indicated that R28 had adequate hearing with the hearing aids. 9/8/21 8:30 AM - 10:00 AM - During an observation of morning care, R28 did not have hearing aids in during morning care. E12 (CNA) and E30 (CNA) directed R28 during care, speaking louder and repeating directions several	F 656	1. Based on record review and interview it was determined that the facility failed to develop a comprehensive resident care plan for the communication needs of a resident with hearing aids including use and care. Corrections to the comprehensive resident care plan for the communication needs of resident R28 with hearing aids including use and care was completed by the Unit Manager (UM) on September 10, 2021. 2. All Residents with hearing aid(s) in the building could have been affected and their care plans will be checked. Any affected residents will have the care plans updated with hearing aids including use and care. 3. RCA: A focus review revealed a need to specify the use and care of the hearing aids specific to each resident. Staff Educators (or designee) will provide education to the Unit Managers and Nursing Supervisors regarding communication needs of a Resident with hearing aid(s) including use and care. 4. The ADON (or designee) will audit charts of Residents with hearing aid(s) for orders in the chart & care plan for use and	

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F 656	Continued From page 18 times when R28 didn't comply with a request or did not perform the task correctly. When R28 was dressed, E12 took the resident to breakfast where he was observed eating without his hearing aides in. 9/8/21 4:52 PM - In a interview, E6 (Gold UM) acknowledged that having hearing aids inserted prior to care would improve resident/staff communication. E6 stated she would update this in the resident's care plan. Findings were reviewed with E1 (NHA), E2 (DON) and E3 (Deputy Director) during the Exit Conference on 9/10/21 at approximately 3:15 PM.	F 656	care of hearing aid(s). The audit will be conducted weekly until 100% compliance is achieved for three consecutive audits. Then the ADON will conduct audits monthly until 100% compliance is achieved for three consecutive audits. Results of the audit will be presented and discussed at the monthly facility QAPI meetings.	
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living:	F 676		10/31/21

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F 676	Continued From page 19 §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview it was determined that for one (R28) out of three residents investigated for hearing/vision, the facility failed to provide care and services to promote communication in the area of hearing. Findings include: Cross refer F656 1. The following was reviewed in R28's clinical record: 6/20/19 - R28 was admitted to the facility with dementia. 12/16/19 - R28's care plan for impaired communication problem lacked approaches for the use and care of his hearing aids. 3/18/20 - R28's Treatment Administration Record showed that the hearing aids should be cleaned	F 676	1. Based on observation, record review and interview it was determined that for R28 investigated for hearing/ vision, the facility failed to provide care and services to promote communication in the area of hearing. As of September 9, 2021, the use and care of R28□s hearing aids was care planned and interventions put in place to facilitate enhanced communication by the Unit Manager (UM). 2. All residents with hearing aid(s) could be impacted by this deficient practice. An audit will be completed of all residents who wear hearing aid(s) to ensure their hearing aid(s) are placed, clean, and properly inserted. Use and Care will be individualized to meet the needs and preferences of each resident.	

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F 676 Continued From page 20
and the battery replaced on Thursday's.

6/22/21 - The annual MDS assessment states R28 had adequate hearing with hearing aids and was usually understood, he missed some parts or the intent of messages, but comprehended most conversations.

9/2/21 - The TAR revealed R28's hearing aids were cleaned.

9/2/21 12:40 PM - During an interview, FM3 (R28's family/POA) stated that staff were not caring for resident's hearing aids properly and showed a picture of the hearing aids that were "caked with ear wax."

9/7/21 12:08 PM - During a random observation, R28 was taken to the dining room by E12 (CNA) with the left hearing aid not in R28's ear canal properly. After the surveyor pointed this out, E12 repositioned the aid, so it was in the ear correctly.

9/8/21 8:30 AM - During an observation of morning care, R28 did not have his hearing aids inserted. E12 (CNA) and E30 (CNA) assisted R28 during care, speaking louder and repeating directions several times when he didn't comply with a request or did not perform the task correctly.

9/8/21 9:15 AM - During an interview, E12 (CNA) reported that the hearing aides were only inserted by the nurse. E12 told E13 (RN) that R28's hearing aids needed to be inserted. E12 then took the resident to breakfast, without his hearing aids.

9/8/21 10:00 AM - During a random observation,

F 676

3. RCA: A focus review revealed a need for orders to specify the use and care of hearing aids and ensure they are placed prior to care, properly positioned and clean.

Staff Educators (or designee) will provide education to the Unit Managers, Nursing Supervisors, licensed staff and CNA's regarding obtaining orders to specify the use and care of hearing aids to include- placed prior to care, properly inserted and clean- especially enhancing communications prior to and during care.

4. The Unit Manager (or designee) will audit residents with hearing aid(s) to ensure they are placed, clean, and properly inserted. The audit will be conducted daily until 100% compliance is achieved for three consecutive audits. Then an audit will be conducted weekly until 100% compliance is achieved for three consecutive audits. Then the Unit Manager (or designee) monthly until 100% compliance is achieved for three consecutive audits.

Results of audits will be brought to the QAPI meetings for review and recommendations.

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F 676	Continued From page 21 R28 was observed in the dining room without his hearing aids, eating breakfast. 9/8/21 4:52 PM - In an interview, E6 (Gold UM) acknowledged that having R28's hearing aids inserted prior to personal care would improve resident/staff communication. 9/9/21 9:30 AM - During an interview, E6 confirmed that she spoke with FM3 (Family/POA) today and FM3 raised a concern over the wax build up in R28's hearing aids. E6 stated she would revise nursing orders to include inserting hearing aids prior to care and to increase cleaning to twice weekly. Findings were reviewed with E1 (NHA), E2 (DON) and E3 (Deputy Director) during the Exit Conference on 9/10/21 at approximately 3:15 PM.	F 676		
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 observation, record review and interview, it was determined that, for one (R48) out of six residents sampled for skin conditions, the facility failed to provide dandruff shampoo treatment as ordered. Findings include:	F 684	1. Based on observation, record review and interview, it was determined that for one resident (R48) the facility failed to provide dandruff shampoo treatment as ordered.	10/31/21

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F 684	Continued From page 22 Review of R48's clinical record revealed the following: 8/9/19 - R48 was readmitted to the facility. 9/13/19 - R48's care plan for the potential for self care deficit was updated to include that R48 often refused showers and needed extra cueing and support. 6/29/21 - Physician's orders included dandruff shampoo (for dry, flaky scalp and itch relief) to be applied directly to the scalp once daily for dry scalp. July 2021 - September 2021 - R48's treatment administration record showed R48's dandruff shampoo treatment was held (declined) on multiple occasions: 15 out of 31 times in July; 28 out of 31 times in August; and 7 out of 7 times as of September 7, 2021. 8/3/21 at 2:03 PM - An email correspondence from FM1 (POA) addressed to E1 (NHA) revealed concerns about R48 including, "worst case of cradle cap...did show it to the nurse...she said she would order Head and Shoulders shampoo...". 8/3/21 at 3:30 PM - A facility grievance form was initiated for concerns including R48's "cradle cap" to scalp. 8/3/21 at 6:13 PM - A nursing progress note documented, "...There was a scant amount of cradle cap noted on the resident's scalp...resident has refused shampoo consistently. MD is aware and will assess...".	F 684	Resident (R48) was assessed by MD on 9/28/21. MD documents continue to encourage resident to accept showers and dandruff treatment as ordered. MD assessment documented that the cradle cap is light and does not interfere with quality of life. No new order. MD assessment was documented in medical record. POA was notified. 2. All residents with an order for dandruff shampoo have the potential to be affected by this deficient practice. A focus review will be completed of medical records for the past month for all residents with an order for dandruff shampoo for refusals, and for affected residents, Unit Manager will complete an SBAR. MD will document assessment and inform Unit Manager or designee of outcome. The Unit Manager (or designee) will notify resident and/or resident's representative. 3. RCA: Facility did not follow the policy of Refusal of Medication and/or Treatment. Staff Educators (or designee) will provide education to Medical and Nursing staff on Refusal of Medication and/or Treatment Policy. 4. The QA Nurse or designee will audit residents with dandruff shampoo for compliance of the policy and if the physician followed-up when notified via SBAR of resident's treatment refusals- weekly until 100% compliance for 3 consecutive audits. Then conduct audits	

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F 684	Continued From page 23 8/3/21 at 6:35 PM - A reply email correspondence from E1 addressed to FM1 documented that, "... aware that he (R48) refuses care and we are not always able to convince him to allow us to groom him as much as he would prefer. He is the resident and has the right to refuse care. This has been discussed during his care plan meetings and interventions are in place to try to convince him to allow us. R48 has a few small dry patches on his scalp. The physician is going to assess him in the a.m. (morning) to determine what treatment will be appropriate. The unit manager will update you after the assessment has been completed." There was no evidence in the record that the physician assessed the resident on or around 8/4/21. 9/10/21 at 9:39 AM - In an interview, E2 (DON) confirmed the lack of evidence that the physician assessed and/or revised the treatment orders to address R48's scalp condition since he had been refusing the dandruff shampoo treatment. 9/10/21 at 10:26 AM - In an interview, E8 (RN Supervisor) stated that she was not aware of R48's cradle cap issue. 9/10/21 at 10:35 AM - In an interview, E14 (Nurse Practitioner) stated that she reviewed R48's physician progress notes and confirmed that the facility lacked evidence that a physician assessment was done to evaluate R48's scalp. E14 added that there was no evidence that the medical team was notified of R48's consistent refusals of the dandruff shampoo treatment.	F 684	monthly until 100% compliance is achieved for 3 consecutive audits. Results of audits will be brought to the QAPI meetings for review and recommendations.	

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F 684	Continued From page 24 9/10/21 at 10:55 AM - In an interview, E9 (RN, UM) confirmed there was no evidence that the medical team was notified about R48's consistent refusal of the dandruff shampoo treatment or that a physician assessment was done to evaluate R48's scalp. Findings were reviewed with E1 (NHA), E2 (DON) and E3 (Deputy Director) during the Exit Conference on 9/10/21 at approximately 3:15 PM.	F 684		
F 685 SS=D	Treatment/Devices to Maintain Hearing/Vision CFR(s): 483.25(a)(1)(2) §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for two (R26 and R33) out of three residents sampled for hearing/vision, the facility failed to ensure that R26 received proper treatment and assistive device to maintain vision abilities. For R33, the facility failed to ensure R33 received proper treatment and assistive devices to maintain hearing abilities. Findings include: 1. Review of R26's clinical record revealed:	F 685	1. Based on record review and interview it was determined that the facility failed to ensure residents (R26, R33) received proper treatment and assistive devices to maintain vision and hearing abilities. Outside facility consultation appointments were obtained by the Unit Manager (UM) for R26 and R33. 2. All residents have potential to be	10/31/21

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F 685	Continued From page 25 6/21/21 - R26 was admitted to the facility. 9/2/21 at 1:11 PM - In an interview, R26 told the surveyor that he requested a pair of eyeglasses from the facility. R26 added that he was not seen by the eye doctor since he was admitted to the facility in June of this year. 9/7/21 at 3:28 PM - E10 (Social Worker) gave the surveyor a written note documenting that R26 had no eye appointment scheduled at this time. 9/8/21 at 8:35 AM - In an interview, E2 (DON) stated that R26 did not have any specific eye consult physician order but "will check." 9/8/21 at 9:19 AM - In an interview, FM2 (POA/Family Member) stated that she participated in the care plan meeting a few weeks ago and requested the facility to set up an eye doctor appointment for R26. 9/8/21 at 11:11 AM - Review of R26's record revealed a new physician's order for "POA requested an eye evaluation." 9/8/21 at 11:37 AM - E2 confirmed that R26's eye doctor appointment was only ordered after the surveyor brought it to the facility's attention. 2. Review of R33's clinical record revealed: 1/20/12 - R33 was admitted to the facility with diagnoses including hearing loss to both ears. 11/26/14 - A care plan was developed for R33's potential for self care deficit with approaches including "Hearing aids in AM out HS (bedtime),	F 685	affected. An audit will be completed of IDCC and Resident Council meetings for the past 30 days to identify any outstanding needs for appointments to ensure proper treatment/ devices to maintain vision and hearing abilities. 3. RCA: Facility did not follow through on obtaining appointments. Staff Educators will provide education to the Unit Managers and OSS's on the process of reporting and documenting consults. 4. QA Nurse or designee will conduct audits of hearing and vision consults. The audit will be conducted daily (weekdays) until 100% compliance is achieved for three consecutive audits. Then an audit will be conducted weekly until 100% compliance is achieved for three consecutive audits. Then monthly until 100% compliance is achieved for three consecutive audits. Results of audits will be brought to the QAPI meetings for review and recommendations.	

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F 685	Continued From page 26	F 685		

left ear very HOH (hard of hearing)."

7/28/21 - Resident Council meeting minutes documented that R33 had expressed concern about audiology (hearing) appointments being made.

8/24/21 - Physician's orders included an audiology consult as hearing aids were not effective.

8/25/21 - Resident Council meeting minutes documented that R33's audiology appointment was being addressed.

9/2/21 at 11:11 AM - In an interview, R33 stated that he requested an audiology appointment to check on his broken hearing aids. R33 added that both hearing aids were not functioning well even when the batteries were replaced and stated "It's taking them (facility) a long time to get this appointment scheduled."

9/7/21 at 3:30 PM - E10 (Social Worker) gave the surveyor a written note documenting that R33 had an audiology consult order written on 8/24/21, "Audiology to be scheduled."

9/8/21 at 2:45 PM - When asked for the recommendation from the audiology consult ordered on 8/24/21, E2 (DON) confirmed that the facility lacked evidence that R33 had an audiology consult and recommendation after 8/24/21 to address R33's complaints of broken hearing aids.

Findings were reviewed with E1 (NHA), E2 (DON) and E3 (Deputy Director) during the Exit Conference on 9/10/21 at approximately 3:15 PM.

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F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §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 record review, interview, and observations it was determined that for one (R29) out of four sampled residents reviewed for dementia care, the facility failed to ensure that the resident received adequate supervision to prevent accidents and failed to ensure the environment was free of accident hazards. Findings include: Review of R29's clinical record revealed: 8/23/18 - R29 was admitted to the facility with dementia. 2/24/21 - A physician note revealed R29 was found with white material at the corner of his mouth, identified as barrier cream (a skin protectant). Poison control was notified, no change in condition was noted. 2/25/21 - R29's care plan was updated to include - nurses and nursing assistants - "keep all non-edible objects out of reach including condiment wrappers, food wrappers, offer snacks, diversions." 6/9/21 3:30 PM - A care plan note revealed R29	F 689	1. Based on record review, interview, and observations it was determined that resident R29, the facility failed to ensure that the resident received adequate supervision to prevent accidents and failed to ensure the environment was free of potential accident hazards. In resident R29's room the toilet was repaired by maintenance worker and all non-edible products secured by Unit Manager on September 10, 2021. UM ensured assigned CNA staff provided increased supervision for resident R29. 2. All resident rooms have the potential to be affected by a broken seat. All toilets in the building were checked for needed repairs. All residents on the Dementia Unit have potential to be affected by unsecured non-edible personal care products. These products have been secured. Unit Manager made staff on the unit aware of identified residents with need for increased supervision due to the potential to consume non-edible items. Unit Manager increased supervision and spot	10/31/21

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F 689	Continued From page 28 was found with a disposable razor and had cuts to his right thumb. 9/2/21 10:15 AM - A cracked toilet seat was observed in R29's bathroom and a tube of barrier cream ointment was found on the back of the toilet. 9/7/21 10:45 AM - R29 was observed walking in the Gold Unit and he entered another residents room without staff redirection. The "stop gate" banner was not fastened across the doorway. 9/7/21 12:49 PM - Denture paste and liquid body wash were observed on R29's bathroom sink. 9/8/21 8:10 AM - R29 was observed in room 1216 (not his room). The fabric STOP banner was not across the door frame. No staff were in the immediate area to redirect E29. 9/8/21 11:51 AM - R29 was observed walking and was carrying a STOP banner in his hand. He was re-directed by staff, who removed the banner from the resident. 9/8/21 4:00 PM - In an interview, E16 (Security Director) confirmed a work order was not received to repair/replace the cracked toilet seat. 9/10/21 12:05 PM - An observation of R29's bathroom revealed the toilet seat had been replaced. At this time, a bottle of liquid soap was observed on R29's bathroom sink and was confirmed with E6 (Gold UM) immediately. Findings were reviewed with E1 (NHA), E2 (DON) and E3 (Deputy Director) during the Exit Conference on 9/10/21 at approximately 3:15 PM.	F 689	checks of 2-3 rooms daily on different shifts and educates staff on need for increased supervision for residents with the potential to consume non-edible items. 3. RCA: We did not self-identify a hairline fracture on a toilet seat. In addition, there was no secure storage area for non-edible personal care products. An area in the rooms on the Dementia Unit will be identified to store all non-edible personal care products. Staff Educators (or designee) will provide education to all Direct Care Staff on the need to store non-edible personal care products in secure storage area and to notify maintenance of any hazards such as a broken toilet seat. Added to education for staff: Need for increased supervision for residents with the potential to consume non-edible items. The electronic health record will be identified for residents who attempt to consume non-edible items and need for increased supervision. 4. Unit Manager or designee will conduct random preventative visual environmental checks. Unit Manager or designee will conduct audits of the cna electronic health record documentation to ensure staff provide increased supervision of residents with the potential to consume non-edible items. The audit will be conducted weekly until 100% compliance is achieved for three consecutive audits. Then monthly until 100% compliance is achieved for	

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F 689	Continued From page 29	F 689	three consecutive audits. Results of audits will be brought to the QAPI meetings for review and recommendations.	
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced	F 755		10/31/21

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F 755	Continued From page 30 by: Based on record review, observation, and staff interview, it was determined that for one (Red Unit, Cart 3) out of three medication carts inspected, the facility failed to accurately reconcile the transfer of controlled drugs from one shift to another. Findings include: 10/25/18 (date of last revision) -The facility policy for "Narcotics: Physician orders, Counting, Discontinued, Documentation" stated that "Controlled Substances must be counted at the change of shifts ...Two (2) nurses must verify drug and count for each controlled medicine and verify the count is the some on the "Controlled Substance Record" form for each medicine ...If count is correct, on the "Narcotic count Sheet" [the nurses will sign the sheet] ...If count is incorrect, the nurse receiving the medication keys will NOT accept the narcotic keys. Instead the nurse: will notify the shift supervisor of the discrepancy immediately and initiate a Medication Error Report ...". 9/9/21 9:45 AM - A narcotic count of Cart 3 on the Red Unit with E31 (RN, UM), it was discovered that one tablet of a controlled substance was missing. The documentation on the facility's "Controlled Drug Record Individual Patient's Narcotic Record" indicated there should be 18 tablets, but there were only 16 tablets in the narcotic box. The last narcotic counts were signed by two nurses as correct at 7:00 PM on 9/8/21 and at 5:45 AM on 9/9/21. The last time a tablet of this medication was signed out by a nurse was at 2:00 PM on 9/8/21 indicating that there should be 17 tablets left in the narcotic box. The nurse assigned to this cart, E32 (LPN), stated he has not given this medication this shift.	F 755	1. Based on record review, observation, and staff interview, it was determined that for Red Unit, Cart 3 the facility failed to accurately reconcile the transfer of controlled drugs from one shift to another. The Red Unit Cart 3 was found to have a documentation counting error but no actual missing medications. The Count was properly reconciled on September 9th, 2021. 2. All Unit Medication Carts have potential to be affected with inaccurate reconciliation at the transfer of controlled drugs from one shift to another. All Unit Medication Carts were checked on September 9, 2021 with no other discrepancies found. 3. RCA: Interviews were completed with the on-coming/off-going licensed staff for that cart that day to find that they did not both visually confirm the counts. Staff Educators (or designee) will provide education to Licensed staff on how to accurately complete controlled/narcotics medications counts. 4. Unit Managers (or designee) will conduct random audits including direct observation of two nurses performing narcotic counts. The audit will be conducted weekly until 100% compliance is achieved for three consecutive audits. Then monthly until 100% compliance is achieved for three consecutive audits. Results of audits will be brought to the	

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F 755	Continued From page 31 Both E31 and E4 (ADON) confirmed this finding. E4 stated he would begin an investigation. 9/9/21 12:45 PM - During an interview, E2 (DON) and E4 confirmed that there was a missing controlled substance tablet and E4 stated he was continuing to investigate. Findings were reviewed with E1 (NHA), E2 (DON) and E3 (Deputy Director) during the Exit Conference on 9/10/21 at approximately 3:15 PM.	F 755	QAPI meetings for review and recommendations.	
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified	F 756		10/31/21

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F 756	Continued From page 32 irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R13) out of six residents reviewed for medication review, the facility failed to ensure the provider reviewed irregularities and failed to ensure the Drug Regimen Review policy included all of the time frame requirements. Findings include: 1. Review of R13's clinical record revealed: 7/19/21 - Review of R13's drug regimen reviews found the pharmacist identified an irregularity and requested an order for a baseline and annual blood tests to monitor R13's liver function and lipid panel since R13 was receiving a medication to control cholesterol. There was no evidence that the physician reviewed this pharmacy concern. 8/31/21 - The pharmacy consultant drug regimen review repeated the same irregularity for a baseline and annual blood tests to monitor liver function and lipid panel. E15 (Medical Director) responded and agreed to order the lipid panel.	F 756	1. Based on record review and interview, the facility failed to ensure the provider reviewed irregularities and failed to ensure the Drug Regimen Review policy included all the time frame requirements for Resident R13. The Medical Director accepted, ordered, and documented on the pharmacist consultant recommendation for the resident (R13) to have bloodwork to monitor liver function. 2. All residents have potential to be affected and the pharmacy recommendations for the past 30 days will be reviewed to ensure that any identified irregularities have documentation and have been addressed or rationale why they were not accepted. 3. RCA: The Drug Regimen Policy does not have specify time frames for the different steps in the process and to address steps to take when an irregularity	

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F 756	Continued From page 33 2. The facility's policy for Drug Regimen Reviews (last revised 11/17/17) included that findings and recommendations should be noted on the monthly drug regimen review report and that this written report would be provided to the attending physician and the director of nursing. The policy did not specify the time frames for the different steps in the process (time frame for pharmacist to provide the report to the facility and for the attending physician to act upon irregularities, including the rationale when not following the recommendation). The policy also did not include the steps the pharmacist must take when an irregularity requiring urgent action was identified. Findings were reviewed with E1 (NHA), E2 (DON) and E3 (Deputy Director) during the Exit Conference on 9/10/21 at approximately 3:15 PM.	F 756	requiring urgent action was identified by the consulting pharmacist. The Drug Regimen Policy will be updated to include: The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record within 30 days. The Attending Physician will be educated by the NHA or designee to review all irregularities within thirty days. The consulting pharmacist will immediately call the attending physician, the DON and/or their designee if they identify an irregularity that requires urgent action to protect the resident. Staff Educators (or designee) to provide education to Administrative Nurses and Medical Director/ Attending Physician on the revised Drug Regimen Review policy. 4. DON (or designee) will audit monthly consulting pharmacist reports to ensure that all recommendations are addressed within 30 days. Any non-compliance will be immediately reported to the Administrator. The audit will be conducted monthly until 100% compliance is achieved for three consecutive audits. Then the audit will be conducted quarterly x 2 until 100 % compliance is achieved. Results of audits will be brought to the QAPI meetings for review and recommendations.	

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F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended	F 758		10/31/21

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F 758	Continued From page 35 beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview it was determined that, for four (R26, R37, R45 and R48) out of six residents sampled for medication review, the facility failed to ensure that psychotropic medications were appropriately ordered and monitored. Findings include: 5/22/18 - The facility policy entitled Behavior Monitoring/Psychotropic drugs included, "A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior...These drugs include, but are not limited to, drugs in the following categories: Anti-psychotic; Anti-depressant; Anti-anxiety; and Hypnotic (for sleep)... [The purpose of this policy includes] to provide guidelines to accurately record monitoring of behavioral symptoms and side effects for residents taking psychoactive medications... PRN [as needed] orders for psychotropic are limited to 14 days... if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order." The policy did not include that PRN antipsychotic	F 758	1. Based on record review, observation, and interview the facility failed to ensure that psychotropic medications were 1) appropriately ordered, 2) appropriately monitored, 3) policy failed to include PRN antipsychotic meds are always limited to 14 days or require physician evaluation per regulation 483.45(e)(5). The physician orders for affected residents (R26, R37, R45, R48) were appropriately ordered by the Unit Managers to ensure all PRN psychotropic orders were limited to 14 days. The AIMS assessment for affected resident (R45) was accurately completed by Licensed Nurse on September 19, 2021. The policy has been amended to include:"483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order". 2. All residents on prn psychotropic medications have the potential to be	

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F 758	Continued From page 36 medications are always limited to 14 days and that the physician must physically evaluate the resident prior to reordering for another 14 days, if the medication is still needed. Side Effect Monitoring 1. Review of R45's clinical record revealed the following: 4/28/21 - R45 was admitted to the facility with several psychiatric disorders including chronic PTSD (post-traumatic stress disorder) from serving in combat and bipolar (manic - depression) disorder. 4/28/21 - An order was written for R45 to receive an antipsychotic medication daily. 5/4/21 - An admission MDS Assessment documented that R45 received an antipsychotic medication daily since admission to the facility. 5/11/21 - A care plan was initiated for potential for adverse side effects related to use of antipsychotic medication and interventions included to monitor for adverse effects. 8/20/21 - An AIMS (Abnormal Involuntary Movement Scale that identifies serious motion side effects of antipsychotic medication) was completed for R45 and documented no abnormal movements in the upper extremities. 9/2/21 4:57 PM - An observation during the resident interview revealed that R45 had noticeable arm tremors (shakiness). 9/9/21 3:30 PM - During an interview, E2 (DON) confirmed that R45 had abnormal involuntary	F 758	affected by this deficient practice. We audited all residents with prn psychotropic medication and AIMS assessments for accuracy. All residents with prn psychotropic medications were given a 14 day stop date by the attending physician. 3. RCA: Behavior Monitoring/Psychotropic Drug Policy was not followed related to limitations on PRN psychotropics. AIMS assessment was completed incorrectly. All residents with PRN psychotropics will be evaluated by the Medical Director/ Attending Physician for discontinuation or converting to routine dosing as appropriate. Staff Educators (or designee) to provide education to Unit Managers, Nursing Supervisors, Consulting Pharmacist and Medical Director and Attending Physician(s) on the Behavior Monitoring/Psychotropic Drug Policy and to Licensed staff on how to complete an accurate AIMS assessment. 4.Audit was revised to include: review medical documentation for rational and duration. Unit managers or designee will conduct Accurate Psychotropic stop dates audits of 10 charts daily x 3, until 100% compliance is achieved. Audits will continue weekly x 3 until 100% compliance is achieved. Audits will continue monthly x 2 months until 100% compliance is achieved. Results of audits will be brought to the QAPI meetings for	

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F 758	Continued From page 37 movements of his upper extremities at the time the 8/20/21 AIMS scale was completed (and since admission to the facility) and that the AIMS scale was incorrect. When asked for a policy/procedure for the AIMS, E2 stated the facility did not have any. In addition, E2 confirmed the 8/20/21 AIMS was the only one completed since R45 was admitted to the facility. There was no evidence that a baseline AIMS scale was performed when R45 was admitted to the facility on daily antipsychotic medications. An inaccurate AIMS scale was completed on 8/20/21. The facility failed to ensure that periodic monitoring for side effects of antipsychotics was completed for R45 according to current standards of practice (on admission and every 6 months). NIH 2014: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4062734/ PRN Orders 2. Review of R48's clinical record revealed: 8/9/19 - R48 was admitted to the facility with diagnoses including anxiety disorder. 8/31/21 - Review of R48's physician orders showed an order for a medication for anxiety to be given every 2 hours as needed for anxiety. This order did not have an end date. 9/9/21 9:00 AM - Findings were discussed and confirmed with E2 (DON). 3. Review of R26's clinical record revealed: 6/21/21 - R26 was admitted to the facility with diagnoses including anxiety disorder.	F 758	review and recommendations. Unit managers or designee will conduct AIMS Accuracy audits on scheduled completed assessments weekly x 3, until 100% compliance is achieved. Random Audits will continue monthly x 3 until 100% compliance is achieved. Audits will continue quarterly x 2 until 100% compliance is achieved. Results of audits will be brought to the QAPI meetings for review and recommendations.	

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F 758	Continued From page 38	F 758		

Continued From page 38

Review of R26's physician orders showed two different medications that could be administered every 2 hours as needed for anxiety without end dates.

a. 6/22/21: gel medication containing an anti-anxiety (Ativan) and an anti-psychotic (Haldol) to be placed on the skin PRN (as needed). Since this medication contained an antipsychotic, every PRN order must be limited to 14 days and the provider must evaluate the resident with each new order.

b. 6/29/21: an oral medication for anxiety (Ativan). The initial order for this medication should be limited to 14 days.

9/8/21 11:00 AM - Findings were discussed and confirmed with E2 (DON).

4. Review of R37's clinical record revealed:

4/7/21 - R37's physician orders included Haldol (an antipsychotic drug to treat mental disorders) to be given three times a day as needed (PRN) for delusions, hallucinations, throwing objects, striking and unable to redirect, without a stop date.

5/11/21 - A Physician order for a gel medication containing anti-anxiety and anti-psychotic medications to be placed on the resident's skin every six hours as needed for anxiety or agitation had a stop date of 12/30/21.

These as needed (PRN) orders contained an anti-psychotic which required a stop date of 14 days.

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F 758	Continued From page 39 5/18/21 - Drug regimen review included "No new recommendations at this time." The drug review by a pharmacist failed to identify the missing or incorrect stop dates for both PRN anti-psychotic medications. 6/8/21 1:59 PM - A pharmacy review of medications identified R37's order for the PRN gel from 5/11/21 was subject to a stop date order per policy. The drug review did not address the PRN Haldol which had been ordered since 4/20/21. 6/9/21 - Physician orders included the addition of a stop date of 12/30/21 to the 5/11/21 PRN gel order. 9/9/21 2:30 PM - An interview to review findings was conducted with E2 (DON). E2 said that the process for renewing anti-psychotic medication should be every fourteen days and E2 was not sure why the physician did not write the order to include a fourteen day discontinuation and renewal as recommended in the pharmacy review. Findings were reviewed with E1 (NHA), E2 and E3 (Deputy Director) during the Exit Conference on 9/10/21 at approximately 3:15 PM.	F 758		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted	F 761		10/31/21

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F 761	Continued From page 40 professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that for one (Gold Unit) out of three medication carts and two (Gold and Red Units) out of three medication rooms inspected, the facility failed to ensure medications were labeled with the resident name and not expired. In addition, in one (Supervisor's office) out of three medication rooms inspected, the facility failed to ensure that all refrigerated drugs and biologicals were stored under proper temperature controls. Findings include: 1. 9/8/21 9:45 AM - During an inspection of the Gold Unit medication cart contents, one box of a liquid medication was found open in the top	F 761	1. Based on observation and interview, it was determined that for one (Gold Unit) out of three medication carts and two (Gold and Red Units) out of three medication rooms inspected, the facility failed to ensure medications were labeled with the resident name and not expired. In addition, in one (Supervisor's office) out of three medication rooms inspected, the facility failed to ensure that all refrigerated drugs and biologicals were stored under proper temperature controls. The Unit Managers discarded and reordered Medications that were identified	

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F 761	Continued From page 41 drawer and not labeled with a resident name or dosage instructions. This finding was immediately confirmed by E13 (RN) who stated that the medication came in a bag with several boxes of medication and only the bag was labeled, not the individual boxes. 9/8/21 4:50 PM - In an interview, E6 (Gold UM) confirmed that the medication should be individually labeled with a patient identifier and dosage instructions. 2. 9/8/21 11:49 AM - An inspection of the Gold Unit medication room, found a bottle of liquid medication with an expiration date of 6/6/21. E13 (RN) immediately discarded the medication. 3. Supervisor's office medication refrigerator 9/8/21 5:00 PM - During an inspection of the Supervisor's office medication room, E4 (ADON) and E8 (RN Supervisor) were unable to locate the medication refrigerator (containing several vaccines and other medications that need to be refrigerated) temperature logs for the months of June and July 2021. In addition, the logs for January, February, and March 2021 had many days when the temperatures were not recorded: - January missing 5 of 31 days (16%) - February missing 10 of 28 days (36%) - March missing 14 of 31 days (45%) 9/9/21 12:45 PM - During an interview, E4 (ADON) confirmed the above finding and stated the facility does not have a policy for medication refrigerator temperature checks, but it is the night supervisor's responsibility to check and record medication refrigerator temperatures every night.	F 761	as outdated or unlabeled. The Unit Managers called the Pharmacy and the pharmacy provided labels for the bottle of medication as well as the box. The Unit Managers of Gold and Red Units labeled the items. Temperature log up to date. 2. All resident's medication/ treatments are at risk for this deficient practice. The unit medication rooms, medication carts and treatment carts were audited for patient medications and are correctly labeled and dated with an expiration date. Temperature log up to date. 3. RCA: Pharmacy failed to provide a label for medications. Staff failed to ensure expired medications were removed from Medication Carts. Staff failed to date an opened ointment medication. Staff failed to ensure medication refrigerator temperature log sheets were complete and maintained in a safe place. DON to change night shift checklist to include a space to sign off that temperature logs are complete. DON/ designee will conduct medication cart audits for undated opened and/ or expired medications. Staff Educators (or designee) to provide education to Licensed staff regarding undated open, unlabeled and or expired medications. Also included, will be how to complete and turn in temperature logs to	

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F 761	Continued From page 42 4. Red Unit medication room 9/9/21 8:30 AM - An inspection of the Red Unit's medication room with E31 (RN, UM), revealed a tube of an ointment medication that was opened and partially used in the drawer with unopened stock medications. The tube was not labeled with a resident's name or the date it was opened. E31 disposed of the medication. 9/9/21 12:45 PM - During an interview, E4 (ADON) confirmed that when the nurse used this tube medication for a resident, it should have been removed from the stock medication drawer, labeled, and put in the resident's med cart. Findings were reviewed with E1 (NHA), E2 (DON) and E3 (Deputy Director) during the Exit Conference on 9/10/21 at approximately 3:15 PM.	F 761	QAPI monthly. 4. DON (or designee) will conduct random audits of medication/treatment carts, medication refrigerators temp logs weekly x 4 until 100% compliance. Results will be reviewed monthly at QAPI meetings for review and recommendations.	
F 790 SS=D	Routine/Emergency Dental Srvcs in SNFs CFR(s): 483.55(a)(1)-(5) §483.55 Dental services. The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(a) Skilled Nursing Facilities A facility- §483.55(a)(1) Must provide or obtain from an outside resource, in accordance with with §483.70(g) of this part, routine and emergency dental services to meet the needs of each resident; §483.55(a)(2) May charge a Medicare resident an additional amount for routine and emergency dental services;	F 790		10/31/21

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DELAWARE VETERANS HOME	**100 DELAWARE VETERANS BLVD MILFORD, DE 19963**

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F 790	Continued From page 43 §483.55(a)(3) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; §483.55(a)(4) Must if necessary or if requested, assist the resident; (i) In making appointments; and (ii) By arranging for transportation to and from the dental services location; and §483.55(a)(5) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for one (R26) out of one resident reviewed for dental services the facility failed to ensure assistance was provided to obtain dental care. Findings include: Review of R26's clinical record revealed: 6/21/21 - R26 was admitted to the facility. 9/2/21 at 1:15 PM - In an interview, R26 told the surveyor that he requested a dental appointment and that he was not seen by the dentist since he was admitted at the facility in June.	F 790	1. Based on the record review and interview it was determined that for resident (R26) facility failed to ensure assistance was provided to obtain dental care. The Unit Manager received an order and scheduled a routine dental appointment on September 8, 2021 for affected resident (R26). 2. All residents have potential to be affected. An audit will be completed of IDCC meetings for the past 30 days to	

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

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F 790	Continued From page 44 9/7/21 at 3:30 PM - E10 (Social Worker) provided the surveyor with a note documenting that R26 had no dental appointment scheduled at this time. 9/8/21 at 8:36 AM - In an interview, E2 (DON) stated that R26 did not have a dental consult order, but she "will check." 9/8/21 at 9:20 AM - In an interview, FM2 (POA/Family Member) stated that she participated in the care plan meeting a few weeks ago and requested the facility to set up a dental consult appointment for R26. 9/8/21 at 10:57 AM - R26's record revealed a new physician's order for "POA requested to resume routine dental appointments." 9/8/21 at 11:38 AM - E2 confirmed that R26's physician order for a dental appointment was only obtained after the surveyor brought it to the facility's attention. Findings were reviewed with E1 (NHA), E2 (DON) and E3 (Deputy Director) during the Exit Conference on 9/10/21 at approximately 3:15 PM.	F 790	identify any outstanding needs for dental care or services. No outstanding needs for dental care or services were identified by IDCC in the past 30 days. 3. RCA: Facility did not follow through on obtaining dental appointment as requested. Staff Educators will provide education to the Unit Managers/Nursing Supervisors, OSS and Social Services on the process of reporting and documenting consults. 4. Social Services Administrator or designee will conduct audits of dental consults. The audit will be conducted daily (weekdays) until 100% compliance is achieved for three consecutive audits. Then an audit will be conducted weekly until 100% compliance is achieved for three consecutive audits. Then monthly until 100% compliance is achieved for three consecutive audits. Results of audits will be brought to the QAPI meetings for review and recommendations.	
F 812 SS=F	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.	F 812		10/31/21

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F 812	Continued From page 45 (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 discovered that the facility failed to ensure food was stored, distributed and prepared in a sanitary manner in accordance to FDA food standards. Findings include: The following was revealed during the initial kitchen tour and nourishment rooms on 9/2/21 from 8:30 AM to 10:00 AM: - The walk-in refrigerator had moldy blueberries and a cardboard box storing purple cabbage and bacon; - The hand washing sink in the dish room was blocked by carts; - The ice machine scoop was stored within the hand washing sink splash zone; - The dining room had unlabeled spray bottles; - The nourishment room on the Red Unit refrigerator was dirty with unlabeled sandwiches; - The nourishment room on the Gold Unit refrigerator was dirty on the bottom. Findings were reviewed and confirmed with E1 (NHA) and E2 (DON) on 9/2/2021 at approximately 3:00 PM.	F 812	1.Based on observations and interviews it was discovered that the facility failed to ensure food was stored, distributed and prepared in a sanitary manner in accordance FDA Food Standards. The moldy blueberries, cabbage, and cardboard box were removed and disposed of by Assistant Food Service Director. The bacon was stored properly in appropriate container. The cart that blocked the hand washing sink in the dish room was removed. The ice machine scoop was permanently relocated from the hand washing sink splash zone by Assistant Food Service Director. The dining room was inspected for unlabeled spray bottles. The Red unit refrigerator was cleaned, and unlabeled sandwich was disposed of by Unit Manager. The Gold unit refrigerator was cleaned on the bottom by Unit Manager. 2. All nourishment rooms refrigerators, dining areas, and kitchen sinks have the potential to be affected by this deficient practice. The Assistant Food Service Director (or	

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F 812	Continued From page 46	F 812	designee) will inspect the kitchen refrigerators to ensure all food is labeled and stored correctly. All areas identified were inspected by AFSD and no additional issues identified with food procurement. 3. RCA: The Kitchen has had a transition in staff, including a new Dietician and recruiting for a new Food Service Director. We did not ensure refrigerators were cleaned, ice machine scoop was stored within the hand washing sink splash zone, food was labeled and stored properly, spray bottles in dining room were labeled, and kitchen sinks were not blocked. The Assistant Food Service Director (or designee) will conduct rounding daily within the dietary department to ensure compliance. The Assistant Food Service Director (or designee) will audit to ensure that food is labeled and dated, hand washing sink is not blocked by carts, the ice machine scoop is stored away from the hand washing sink splash zone, and the dining room spray bottles are labeled correctly. The Nursing Supervisor (or designee) will conduct audits of food in the nourishment room refrigerators to ensure food is labeled and dated, any expired food will be removed and disposed of. Staff Educators (or designee) will provide education to Dietary staff and nursing staff on the regulation for food storage. 4. The Assistant Food Service Director (or designee) will audit that refrigerators	

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F 812	Continued From page 47	F 812	clean, food labeled and stored properly, spray bottles in dining room labeled, and kitchen sinks not blocked. Each audit will be conducted daily until 100% compliance for 21 consecutive days. Then will conduct each audit for compliance weekly x 3 until 100% compliance is achieved for 3 consecutive weeks. Then will conduct each audit for compliance monthly x 3 until 100% compliance is achieved for 3 consecutive months. Results of the audit will be presented and discussed at the monthly facility QAPI meetings. The Nursing Supervisor (or designee) will conduct audits daily of food in the unit nourishment room refrigerators to ensure food is labeled and dated. Each audit will be conducted daily until 100% compliance for 21 consecutive days. Then will conduct each audit for compliance weekly x 3 until 100% compliance is achieved for 3 consecutive weeks. Then will conduct each audit for compliance monthly x 3 until 100% compliance is achieved for 3 consecutive months. Results of the audit will be presented and discussed at the monthly facility QAPI meetings.	
F 943 SS=E	Abuse, Neglect, and Exploitation Training CFR(s): 483.95(c)(1)-(3) §483.95(c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- §483.95(c)(1) Activities that constitute abuse,	F 943		10/31/21

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F 943	Continued From page 48 neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. §483.95(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property §483.95(c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on review of facility documentation and interview it was determined that for fourteen (E9, E17, E18, E19, E20, E21, E22, E23, E24, E25, E26, E27, E28 and E29) out of fourteen sampled staff members, the facility failed to ensure that staff received annual training on dementia and/or abuse in the previous twelve months. Findings include: Review of a facility-completed spreadsheet entitled Staff Training and Vaccination and training records revealed the latest training dates on dementia: - 1/20/20: E17 (CNA). - 3/25/20: E18 (CNA), also missing abuse training. - 6/13/20 : E23 (RN). - 6/15/20: E9 (RN), E28 (Grounds) and E29 (Volunteer Services). - 6/16/20: E19 (CNA), E20 (CNA) and E27 (Activities). - 6/17/20: E21 (CNA), E24 (RN) and E25 (LPN). - 7/1/20: E26 (OT). - None in 2020: E22 (LPN). 9/9/21 2:47 PM - The lack of education in the past year was reviewed with E2 (DON).	F 943	1. Based on record review and interview it was determined that the facility failed to ensure that staff received annual abuse and/or dementia training in the previous twelve months for E9, E17, E18, E19, E20, E21, E22, E23, E24, E25, E26, E27, E28 and E29. Education will be provided by staff educator(s) on abuse and dementia training for E9, E17, E18, E19, E20, E21, E22, E23, E24, E25, E26, E27, E28 and E29 (the above staff). 2. All employees in the facility have the potential to be affected by this deficient practice and will receive annual training on abuse and dementia. All employee education plan records from prior staff educator were reviewed. It was inconclusive and thereby determined that all staff would receive dementia and abuse training by October 31,2021 from current staff educator(s). 3. RCA: Facility did not have a systemic approach to mandatory education process.	

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F 943	Continued From page 49 9/10/21 8:10 AM - Review of additional documents provided by the facility found no additional education records. Findings were reviewed with E1 (NHA), E2 (DON) and E3 (Deputy Director) during the Exit Conference on 9/10/21 at approximately 3:15 PM.	F 943	Administrator will educate the Administrative Nursing Team to the requirement for annual abuse and dementia training. Then the Staff Educators will train the employees on abuse and dementia training and ensure completion of training by all employees. A new systemic approach tracking system was created by the staff educator(s) to identify staff completion of annual training including abuse and dementia training. Staff Educator(s) created a new systemic approach on an Excel Spreadsheet. This spreadsheet includes the name of all staff members and the date Abuse and/ or dementia training was completed. Staff Educator(s) will review at the beginning of each month to determine which staff members are due and notify those staff members to ensure completion. 4. Abuse and dementia education will be completed for all current staff by October 31,2021 as per the plan of correction date certain. The Regulatory Specialist (or designee) will conduct monthly audits to ensure that 100% compliance is achieved. If 100% compliance is achieved, the deficiency will be considered resolved. Results of the audit will be presented and discussed at the monthly facility QAPI meeting.	