STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085057	A. BUILDING _____ B. WING _____	C 01/08/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTER AT EDEN HILL, LLC	300 BANNING STREET DOVER, DE 19904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced annual and complaint survey was conducted at this facility from January 2, 2020 through Janurary 8, 2020. The facility census the first day of the survey was 47. During this period an Emergency Preparedness Survey was also conducted by the State of Delaware's Division of Health Care Quality Long Term Care Residents Protection in accordance with 42 CFR 483.73. For the Emergency Preparedness Survey no deficiencies were identified.	E 000		
F 000	INITIAL COMMENTS Revised report following IDR held on 2/6/2020. The following changes were made to the report: F645, F655 and F880 were deleted. F684 was revised. Scope and severity remains the same. An unannounced annual and complaint survey was conducted at this facility beginning January 2, 2020 and ending January 8, 2020. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census on the entrance day of the survey was 47 residents. The investigative sample totaled nineteen (19). Abbreviations used in this report are as follows: NHA - Nursing Home Administrator; DON - Director of Nursing; ADON - Assistant Director of Nursing; RN - Registered Nurse; LPN - Licensed Practical Nurse;	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/29/2020

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

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F 000	Continued From page 1 MD - Medical Doctor; UM - Unit Manager; NP - Nurse Practitioner; CNA - Certified Nurse's Aide; Antipsychotic - drug to treat psychosis and other mental/emotional conditions (e.g. Risperdal, Seroquel); Anxiety - feeling worry, nervous or restless; cerebral - pertaining to the brain; Congestive heart failure - (CHF) - heart cannot pump enough blood to meet the body's needs; Depression - mood disorder with feelings of sadness; Diuretic - medicine to reduce water/excess fluid in the body; edema - swelling; EMR - Electronic Medical Record - computerized medical record; Furosemide - a medicine to reduce water/excess fluid in the body; MAR - Medication Administration Record - record of the drugs administered to a patient at a facility; MDS - Minimum Data Set - standardized assessment forms used in nursing homes; MG - milligram - unit of measurement; ML (milliliters) -unit of liquid volume, 5 ml equals 1 teaspoon; PASARR - Pre-admission Screening and Resident Review; Psychosis - loss of contact/touch with reality; PRN - As needed; Seroquel - antipsychotic; Tab - tablet; Zoloft - a medication used to treat depression.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)	F 656		3/8/20

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F 656	Continued From page 2 §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. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the	F 656		

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F 656	Continued From page 3 requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and interviews, it was determined that the facility failed to ensure that for one (R18) out of 19 residents reviewed in the investigative sample the facility failed to develop a comprehensive person-centered care plan to address R18's edema and use of a diuretic. Findings include: Review of R18's clinical record revealed the following: 11/22/19 - R18 was admitted to the facility with a history of congestive heart failure. 12/24/19 6:32 PM - A progress note documented that R18 had edema to the right and left lower extremities. R18 was encouraged to elevate her legs as much as possible. 12/25/19 5:24 PM - A new physicians order for a 1500 ml fluid restriction. Dietary 1140 ml, nursing 360 ml split between the three shifts 11:00 PM to 7:00 AM allowed 60 ml 7:00 AM to 3:00 PM allowed 150 ml and 3:00 PM to 11:00 PM allowed 150 ml. 12/27/19 - A physician's order for furosemide 40 mg 1 tab in the morning for edema. 1/3/20 - A review of R18's record lacked evidence that fluid was being monitored per the physicians order. During an interview with E2 (DON) on 1/8/20 at 1:55 PM it was confirmed that the facility did not	F 656	R18 is no longer at the facility and was not adversely affected by this practice. All patients on a fluid restriction and/or having the diagnosis of edema have the potential to be affected by this practice. ADON/DON or designee will in-service the nurses regarding completing care plans for fluid restrictions and/or edema. A root cause analysis has been completed and it was determined the facility did not review the new order for fluid restriction and ensure the appropriate care plan was in place. ADON/DON or designee will in-service all nurses on the importance of completing care plans for patients with fluid restrictions and/or edema and any new orders that require a care plan. ADON/DON or designee will perform weekly audits ADON/DON or designee will perform weekly audits for all patients on fluid restrictions and/or with dx of edema to ensure care plans have been completed x 4 weeks until 100% success is achieved, then monthly x 2. The weekly audits will be submitted and discussed at the monthly QAPI and committee will decide if further audits will be needed.	

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F 656	Continued From page 4 have a care plan that addressed R18's diuretic use, fluid restriction, and edema. E2 did reveal that the care plan was now updated. Findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) during the exit conference, beginning at approximately 3:00 PM on 1/8/20.	F 656		
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 observations, record reviews and interviews, it was determined that the facility failed to ensure that for one (R18) out of one sampled residents reviewed for edema received treatment and services in accordance with the physician's prescribed plan of care. For R18, the facility failed to monitor a fluid restriction per the physician's order. Findings include: Review of R18's clinical record revealed the following: 11/22/19 - R18 Admitted to the facility with a history of congestive heart failure. 12/24/19 6:32 PM - A progress note documented that R18 had edema to the right and left lower	F 684	R18 is no longer at the facility and was not adversely affected by this practice. All patients have the potential to be affected by this practice. ADON/DON or designee will in-service the nurses regarding correct order entry in emar system to properly indicate assigned MLs per shift to monitor patients fluid intake to ensure proper hydration within physician order fluid restrictions/allowance. A root cause analysis has been completed and it has been determined that supplemental documentation for MLs was not added during order entry into EMAR. ADON/DON or designee will in-service all	3/8/20

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F 684	Continued From page 5 extremities. R18 was encouraged to elevate her legs as much as possible. 12/25/19 5:24 PM - A new physician's order for a 1500 ml fluid restriction included: Dietary 1140 ml, nursing 360 ml split between the three shifts 11:00 PM to 7:00 AM allowed 60 ml 7:00 AM to 3:00 PM allowed 150 ml and 3:00 PM to 11:00 PM allowed 150 ml. 12/27/19 - A physician's order for furosemide 40 mg 1 tab in the morning for edema. 1/2/20 9:51 AM - R18's lower legs were observed swollen. 1/3/20 at 2:30 PM - R18's lower legs were observed swollen. 1/3/20 - A review of R18's record lacked evidence that daily fluid totals were being monitored to ensure fluid restriction per the physician's order. During an interview with E6 (CNA) on 1/6/20 at 11:28 AM it was revealed that E6 would have to ask the nurse about giving fluids to a resident that was being monitored for a fluid restriction. During an interview with E4 (LPN) and E5 (RN) on 1/6/20 at 11:48 AM, it was confirmed that no fluid intake amounts were documented in the electronic medical record for R18. E4 updated the fluid restriction order so that nursing would enter the amount of fluid consumed in the electronic record. 1/6/20 at 3:50 PM - R18's lower legs were observed swollen.	F 684	nursing staff/RD regarding the order entry process for documenting assigned MLs per shift and monitoring fluid intake per shift for all patients on fluid restrictions to ensure compliance for adequate fluid intake as per physician orders. ADON/DON or designee will perform weekly audits for all patients on fluid restrictions to ensure there is no over hydration nor under hydration x 4 weeks until 100% success is achieved, then monthly x 2. The weekly audits will be submitted and discussed at the monthly QAPI and committee will decide if further audits will be needed.	

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F 684	Continued From page 6 1/7/20 10:52 AM - R18's lower legs were observed swollen. Documentation on fluid intake totals each day, recorded by CNA (dietary) and Nursing, were below the 1500 mL requirement as calculated by the surveyor from documentation provided by the facility on 1/23/20: 12/25/19 960 mL 12/26/19 840 mL 12/27/19 980 mL 12/28/19 960 mL 12/29/19 960 mL 12/30/19 960 mL 12/31/19 840 mL 1/1/20 840 mL 1/2/20 840 mL 1/3/20 840 mL 1/4/20 720 mL 1/5/20 960 mL 1/6/20 840 mL 1/7/20 1080 mL It was unclear how the facility was monitoring for fluid overload and/or inadequate fluid intake for R18 who was on a 1500 mL fluid restriction. Findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) during the exit conference, beginning at approximately 3:00 PM on 1/8/20.	F 684		

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: Center of Eden Hill

DATE SURVEY COMPLETED: January 8, 2020

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTIONOF 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 beginning January 2, 2020 and ending January 8, 2020. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census on the entrance day of the survey was 47 residents. The investigative sample totaled nineteen (19). (Revised report from Informal Dispute Resolution (IDR) conducted February 6, 2020.)		
3201	**Regulations for Skilled and Intermediate Care Facilities**		3-8-2020
3201.1.0	**Scope**		
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:** Cross Refer to the CMS 2567-L survey completed January 8, 2020: F656, F684, and F842.	Cross Reference POC for CMS 2567-L survey completed January 8, 2020 F-Tags F656, F684, F842 Completion date March 8, 2020	

Provider's Signature Johnanne M Tedellini, LNHA Title Executive Director Date 3/6/2020