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	085004	A. BUILDING _____ B. WING _____	C 11/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGS REHABILITATION AT BRANDYWINE	505 GREENBANK ROAD WILMINGTON, DE 19808

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 806	Continued From page 91 primary menu." 11/12/24 2:35 PM - Findings were discussed with E1 (NHA), E2 (DON) and E47 (Regional Clinical Consultant). 2. 11/1/24 11:00 AM - R78 reported that the facility breakfast meal is always determined by the kitchen, and that there are no alternative meal choices for breakfast. Additionally, there are no breakfast items on the "always available menu". 11/12/24 8:30 AM - During an interview, E28 (Food Service Director) confirmed that the facility does not have an alternative breakfast menu and that there are no breakfast items on the "always available menu" food list. 11/13/24 3:00 PM - Findings were reviewed with E1 (NHA), E2 (DON), E47 (RCC), E58 (RDO) and a representative from the Ombudsman's office.	F 806		
F 807 SS=E	Drinks Avail to Meet Needs/Prefs/Hydration CFR(s): 483.60(d)(6) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(6) Drinks, including water and other liquids consistent with resident needs and preferences and sufficient to maintain resident hydration. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that for 10 (R6, R11, R14, R52, R69, R78, R99, R103, R105 and R106) out of 13 residents reviewed for food, the	F 807	A. The facility cannot retroactively correct the issue related to R6, R11, R14, R52, R69, R78, R99, R103, R105, R106. Food items listed on meal tickets are to be	1/2/25

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F 807	Continued From page 92 facility failed to provide each resident with drinks consistent with each residents' needs and preferences. Findings include: 1. R6's clinical record revealed: 10/29/24 10:50 AM - During an interview, R6 stated that fluids are not always offered during the day. R6 stated that "I have to ask." Review of the facility form entitled Brandywine 3 C.N.A. assignment, revised 5/8/23, stated, "... ALL ASSIGNMENTS PASS OUT YOUR OWN WATER...". 11/6/24 12:16 PM - Surveyor observed R6 in bed with a white Styrofoam cup dated 11/5/24 7-3 PM sitting on her bedside table. During an interview, the Surveyor asked R6 if she was offered fresh water since the date and shift on the Styrofoam cup. R6 said "No." The facility failed to offer water to R6 on the two prior shifts. 11/12/24 1:30 PM - Finding was reviewed with E1 (NHA), E2 (DON), E4 (LPN/QA/IC) and E47 (RCC). 2. 10/31/24 - An observation on the B unit from 9:07 AM through 9:55 AM revealed the following residents' meal trays which did not include coffee or tea beverages contrary to what was indicated in their breakfast meal tickets: R14 - no coffee or hot tea; R106 - no coffee or hot tea; R105 - no coffee or hot tea; R52 - no unsweetened coffee or hot tea; R103 - no coffee or hot tea; R78 - no unsweetened coffee or hot tea;	F 807	provided on meal trays, food service director and or designee will monitor tray line for accuracy. B. The food service director, assistant director, and dietary staff were educated on 11/16/24 by the regional dining consultant regarding tray line accuracy and following the meal tickets. C. The root cause was determined to be due to lack of oversight, and education, from the food service director and dietary staff. If an item is unavailable the food service director will notify the residents prior to meal service. The unavailable item will be crossed off on the meal ticket, the food service director and dietary staff received additional education on this on 11/16/24. D. The food service director/designee will audit trayline for accuracy to ensure that all requested items are received. The audits will be completed daily, or once 100% compliance is achieved, for three consecutive days. The audits will continue to occur 3x a week for 3 consecutive weeks, or until 100% compliance is achieved. Audits will continue monthly until 100% compliance is achieved for 3 consecutive months. Once 100% compliance is sustained the deficient practice will be considered resolved. Results of all audits will be presented to the Quality Assurance and Performance Improvement Committee for further evaluation, recommendations, and sustainability plan.	

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F 807	Continued From page 93 R99 - no coffee or hot tea; R11 - no coffee or hot tea; and R69 - no coffee or hot tea. 10/31/24 9:13 AM - During an interview, E65 (CNA) confirmed that R14, R106 and R105 did not have coffee nor tea on their meal trays. 10/31/24 9:23 AM - In an interview, E64 (CNA) confirmed that R52, R103, R78, R99, R11 and R69 did not have coffee nor tea on their meal trays. 10/31/24 9:40 AM - In a follow up interview, E64 also stated, "It happens all the time that the residents on this (B) unit are not getting their coffee or tea. If the resident requests for it, then we go to the kitchen and ask." 11/1/24 10:21 AM - In an interview, E8 (Dietary Supervisor) stated that she was not aware that some residents in the B unit did not receive their hot coffee or hot tea beverages in their meal trays. E8 further confirmed that it was a breakdown in the kitchen system and that she will need to educate the kitchen staff on the use of the coffee machine. 11/6/24 3:50 PM - During interview, E34 (Regional Dietary Consultant) stated that "if a resident's meal ticket indicated coffee or tea, then the resident should have coffee or tea in his/her meal tray." In nine (9) out of 27 residents on the B unit, the facility failed to ensure that other liquids, such as coffee or tea, were provided with their breakfast meal trays to encourage fluid intake.	F 807		

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F 807	Continued From page 94 11/12/24 2:35 PM - Finding was discussed with E1 (NHA), E2 (DON) and E47 (Regional Clinical Consultant).	F 807		
F 809 SS=D	Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: Based on review of the facility's scheduled meal times and interview, it was determined that for two (R23 and R78) out of 13 residents reviewed for food, the facility failed to ensure that R23 and R78 received their evening snacks. Findings include: 1. Review of R23's clinical record revealed: 8/3/21 - R23 was admitted to the facility.	F 809	A. The facility cannot retroactively correct the issue related to R23 and R78. The Bulk snack distribution list was reviewed and revised on 11/11/24, par levels were increased for each unit for all bulk snacks- sandwiches, milk, pudding, and a variety of snack options were increased. B. The food service director, assistant	1/2/25

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F 809	Continued From page 95 10/28/24 12:38 PM - In an interview, R23 told surveyor that she was not getting her bedtime or evening snacks. She further stated, "You have to call the girls (nursing staff) and ask for food. I am a big girl, I always get hungry at night... When I asked from the girls, they told me that the kitchen people told them that there were no more snacks." 10/28/24 2:00 PM - Review of R23's CNA flowsheet from September 2024 through October 2024 revealed a lack of evidence that R23 was provided evening snacks. 11/1/24 4:05 PM - During interview, E42 (CNA) stated, "... A few weeks ago... 2-3 times in a week there were no evening snacks... Sometimes we keep our back up oatmeal cookies or fudge in the Unit Manager's office but she (Unit Manager) locks the room after 3:00 PM. We were not able to access the back up snacks. Kitchen won't give us enough snacks to be distributed to the residents." 11/1/24 4:14 PM - In an interview, E43 (CNA) stated that they give out evening snacks but there were nights when the snacks were not enough. E41 confirmed and stated, "... Sometimes we don't have anything to give at all... Other times we want to get the back up snacks in the Unit Manager's room but we can't go in because the room is locked." 2. Cross refer F561 and F802, example 2 11/1/24 11:00 AM - During an interview, R78 stated that the facility does not always provide evening snacks. R78 stated that because the	F 809	food service director, and dietary staff were educated on the par levels for snack distribution and completing the snack delivery log on 11/12/24. The dietary staff assigned to distribute snacks to the units is responsible for putting together the trays of bulk snack items and delivering them to each unit. C. The root cause analysis determined that staff failed to follow recommended par levels of bulk snack items. The dietary staff received additional education on 11/25/24, by regional dining consultant and the food service director, regarding updated par levels and snack delivery log completion. D. The food service director, or designee, will conduct audits to ensure the snacks are being delivered to the units and available for the residents when requested. The audits will be completed daily, or once 100% compliance is achieved, for three consecutive days. The audits will continue to occur 3x a week for 3 consecutive weeks, or until 100% compliance is achieved. Audits will continue monthly until 100% compliance is achieved for 3 consecutive months. Once 100% compliance is sustained the deficient practice will be considered resolved. Results of all audits will be presented to the Quality Assurance and Performance Improvement Committee for further evaluation, recommendations, and sustainability plan.	

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F 809	Continued From page 96 timing of each meal is unpredictable, and that bedtime snacks are sometimes not provided, she was aware that many of the residents in the facility stored food in their rooms. R78 stated that they cannot depend on the facility to provide their food or bedtime snacks timely. 11/13/24 3:00 PM - Findings were reviewed with E1 (NHA), E2 (DON), E47 (RCC), E58 (RDO) and a representative from the Ombudsman's office.	F 809		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure food/items were stored and/or prepared under	F 812	A. 1. The items that were found in the walk-in refrigerator and freezer that were	1/2/25

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F 812	Continued From page 97 sanitary conditions. Findings include: 1. During the initial tour of the kitchen on 10/28/24 beginning at 9:00 AM, the following observations were made: - The walk-in freezer contained bread, ice cream, and debris on the floor; - The standard refrigerator near the entrance had a pink and orange substance spilled inside at the base; - The dry food storage room revealed three bags of onions, a bag of potatoes, and a container of icing stored on the floor; - A pan with meat that was to be seasoned was located on a table uncovered and unattended; - A prepared salad located inside the refrigerator without a date; - In the ware washing room, the table in the dish area where the clean dishes come out of the ware washing machine was covered in food debris; - In the ware washing room, clean plastic mugs were stored inside the room placing them at risk of exposure to splash and in a wet location. The plastic mugs had visible white spots on them; and - Paper towels were not available at the hand washing sink. A follow-up visit to the kitchen on 10/30/24 at 11:30 AM found: - The walk-in freezer with small containers of ice cream and muffins turned over on the floor; - A box of muffins was left partially uncovered; and - In the ware washing room, the table in the dish area where the clean dishes come out of the ware washing machine contained visible food debris.	F 812	expired, opened, or without a label and date were immediately discarded. The substance that was found on the bottom of the reach in refrigerator was cleaned up. The food items that were improperly stored in the dry storage room were picked up off the floor and placed on crates. The pan of meat sitting out to be seasoned was discarded by the assistant food service director. The food debris that was found in the unloading area, in the dish room, was removed and the area was cleaned and sanitized. The hand washing sink paper towel dispenser was filled with paper towels immediately. The above areas of concern were addressed on 10/28/24 by assistant food service director and regional dining consultant. The rack the clean cups and bowls sit on was removed from the dish room on 10/31/24 and dollies were purchased for racks of clean wares to be stored on. 2. Personal food items were removed from pantry refrigerators and food items without a label and date were discarded immediately. B. 1.The regional dining consultant completed a walk through of all food storage areas on 10/31/24 to ensure all food items were properly stored, labeled, and dated. The regional dining consultant completed a sanitation audit on 10/31/24, to ensure the dish machine area was cleaned and the paper towel dispenser was filled with paper towels. 2. The pantry refrigerators were checked by assistant food service director on	

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F 812	Continued From page 98 2. 11/1/24 11:20 AM - An observation on the snack/nourishment refrigerator serving B, C, D and E units revealed a personal lunch bag and food items with no date and no label in Styrofoam inside an undated and unlabeled plastic bag. 11/1/24 11:23 AM - Findings were confirmed by E40 (RN). 11/12/24 2:35 PM - Findings were discussed with E1 (NHA), E2 (DON) and E47 (Regional Clinical Consultant).	F 812	11/3/24 to ensure all food items were labeled and dated and personal food items were not being stored. C. 1. The root cause analysis determined that staff failed to follow policy and procedure for food safety, storage, and sanitation by not properly storing, labeling or dating food items. This staff also failed to properly clean and sanitize food storage areas, the dish room, and dish machine area. All dietary staff received additional education, on the food storage and food safety & sanitation policy, on 11/16/24 by the food service director and regional dining consultant. D. The food service director, or designee, will conduct audits to ensure the food storage and the food safety & sanitation policy is being followed. The audits will be completed daily, or once 100% compliance is achieved, for three consecutive days. The audits will continue to occur 3x a week for 3 consecutive weeks, or until 100% compliance is achieved. Audits will continue monthly until 100% compliance is achieved for 3 consecutive months. Once 100% compliance is sustained the deficient practice will be considered resolved. Results of all audits will be presented to the Quality Assurance and Performance Improvement Committee for further evaluation, recommendations, and sustainability plan.	
F 842 SS=E	Resident Records - Identifiable Information	F 842		1/2/25

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F 842	Continued From page 99 CFR(s): 483.20(f)(5), 483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert	F 842		

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F 842	Continued From page 100 a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for eleven (R16, R18, R33, R38, R43, R55, R94, R113, R310, R456 and R457) out of forty-two residents reviewed for resident records, the facility failed to maintain complete, accurate and readily accessible resident medical records. Findings include: 1. Review of R38's clinical record revealed:	F 842	(1) A. The facility cannot retroactively correct the issue R33, R94, R310, R456 and R457 record was revised to reflect adequate indication/ medical diagnosis for the anticoagulation medication. The facility cannot retroactively correct the issue r/t R18 and R55	

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F 842	Continued From page 101 4/19/24 - R38 was admitted to the facility. 10/22/24 1:39 PM - R38's urine culture specimen that was ordered by E3 (MD) was received at the laboratory. 10/24/24 4:05 PM - R38's urine culture results were received at the facility stating "1 Organism growth". 10/24/24 11:21 PM -E52 (NP) documented in R38's EMR that the urine culture was reviewed. 11/12/24 12:53 PM - During an interview, E4 (LPN/IP) confirmed that [contracted laboratory] does not upload final culture results to the residents' EMR. "The facility gets the final results and then sends the results in an email group to all the providers but it is not in the resident's records. 11/13/24 10:30 AM - The facility provided the surveyor with a copy of R38's 10/22/24 urine culture final microbiology report with sensitivity. 2. Cross refer F881, example 1 Review of R43's clinical record revealed: 9/20/24 - R43 was admitted to the facility. 10/10/24 1:00 PM - R43's urine culture specimen that was ordered by E3 (MD) was received at the laboratory. 10/12/24 3:20 PM - R43's urine culture results were received at the facility stating "1 Organism growth". 10/14/24 11:36 AM - E51 (NP) documented in	F 842	B. Active residents receiving anti-coagulants medications will be reviewed to ensure adequate indication/ medical diagnosis is in place for use. Current residents with tube feeding will be reviewed for flushes documentation for accuracy. C. The root cause was determined to be due to lack of consistent oversight during medication review and oversight when providers enter a medication order. Staff Development/Designee will educate licensed nurses to ensure adequate indication/ medical diagnosis is in place for anticoagulant use. ADON/Designee will review residents on anticoagulant medication to ensure adequate indication/ medical diagnosis is in place for use. Medical Director/Designee will educate providers to ensure adequate indication/ medical diagnosis is in place when ordering anticoagulant medications. D. Daily audit by DON/Designee to ensure adequate indication/ medical diagnosis is in place for anticoagulant use x 5 days or until 100% compliance is achieved and sustained. The following will be a weekly audit x 4 then monthly x 3 months with a goal of 100% achieved and sustained. In an event where compliance is consistently below the goal, the Interdisciplinary Team	

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F 842	Continued From page 102 R43's EMR that the urine culture was reviewed. 11/12/24 - The facility was not able to produce evidence of R43's 10/10/24 urine culture final microbiology report with sensitivity for the surveyor to review. 3. Review of R113's clinical record revealed: 11/25/22 - R113 was admitted to the facility. 10/4/24 1:53 PM - R113's urine culture specimen that was ordered by E3 (MD) was received at the laboratory. 10/6/24 3:48 PM - R113's urine culture results were received at the facility stating "1 Organism growth". 10/14/24 11:36 AM - E21 (RN/UM) documented in R113's EMR that the urine culture was reviewed. 11/12/24 12:53 PM - During an interview, E4 (LPN/IP) confirmed that [contracted laboratory] does not upload final culture results to the residents' EMR. "The facility gets the final results and then sends the results in an email group to all the providers but it is not in the resident's records. 11/13/24 10:30 AM - The facility provided the surveyor with a copy of R113's 10/4/24 urine culture final microbiology report with sensitivity. 4. Review of R33's clinical record revealed: 9/30/24 - R33 was admitted to the facility with diagnoses, including but not limited to, heart failure, morbid obesity and chronic atrial	F 842	(IDT) will meet with the QA Committee to review the process, and revision will be made to maintain and sustain compliance. (2) A. The facility cannot retroactively correct the issue. R38, R113 urine culture results were obtained for resident records. R43 cannot be retroactively corrected. B. Active residents with urine culture obtained within the last 14 days will be reviewed to ensure it is available in the EMR. C. The root cause was determined to be due to lack of consistent process when a laboratory report has resulted and uploaded to EMR. The root cause was also determined to be due to lack of consistent follow through when a urine culture result is received. Staff development/Designee will educate licensed nurses to ensure urine cultures are reviewed and uploaded in the EMR. Daily, all pending culture results will be reviewed to ensure staff are compliant with the process for obtaining and uploading of culture. D. Daily audit by DON/Designee to ensure appropriate urine culture results are obtained and uploaded in the EMR x 5	

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F 842	Continued From page 103 fibrillation (Afib). 9/30/24 - E3 (MD) ordered in R33's electronic medical record (EMR), "Rivaroxaban oral tablet 20 mg (milligrams)- give one tablet by mouth one time a day for anticoagulant." Atrial fibrillation placed R33 at risk of having her blood clot. The goal of prescribing rivaroxaban was to prevent R33's blood from clotting or to place R33 in a state of anticoagulation. Anticoagulation is not a medical diagnosis; it is a physiologic state. However, R33's medical history included a diagnosis that was a medical indication for the drug rivaroxaban, Afib. Therefore, atrial fibrillation was the medical diagnosis for R33 requiring the drug, rivaroxaban. "Anticoagulant" was not an adequate indication/ medical diagnosis for the order for R33's rivaroxaban. 5. Review of R94's clinical record revealed: 6/6/24 - R94 was admitted to the facility with diagnoses, including but not limited to, chronic Afib, peripheral vascular disease and rheumatic mitral stenosis. 10/8/24 - E52 (NP) ordered in R94's EMR, "Warfarin Sodium oral tablet 2 mg - give one tablet by mouth one time a day every Monday, Tuesday, Wednesday, Thursday for anticoagulation." E52 also ordered in R94's EMR Warfarin Sodium oral tablet 3 mg- give one tablet by mouth one time a day every Friday, Saturday, Sunday for blood thinner." Atrial fibrillation placed R94 at risk of having her	F 842	day or until 100% compliance is achieved and sustained. The following will be a weekly audit x 4 then monthly x 3 months with a goal of 100% achieved and sustained. In an event where compliance is consistently below the goal, the Interdisciplinary Team (IDT) will meet with the QA Committee to review the process, and revision will be made to maintain and sustain compliance. (3) A. R16's Kardex/care plan has been clarified to indicate prompted toileting program and routine checks for incontinent care. B. Active residents with incontinent episodes will be reviewed to ensure Kardex/comprehensive care plan reflects appropriate toileting program as indicated. C. The root cause is determined to be due to lack an oversight with ensuring kardex and care plan reflects appropriate toileting program as indicated. Staff Development/Designee will educate licensed nursing staff /RNAC regarding appropriate toileting program being reflected in the kardex and care plan. D. Daily audit by DON/Designee to ensure appropriate kardex and care plan reflects toileting program as indicated x 5 day or until 100% compliance is achieved and	

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F 842	Continued From page 104 blood clot. The goal of prescribing warfarin was to prevent R94's blood from clotting or to place R94 in a state of anticoagulation. Anticoagulation is not a medical diagnosis; it is a physiologic state. However, R94's medical history of Afib was a medical indication for the drug warfarin. Therefore, atrial fibrillation was the medical diagnosis for R94 requiring the drug, warfarin. "Anticoagulation" and "blood thinner" were not adequate indications/ medical diagnoses for the order for R94's warfarin. 6. Review of R310's clinical record revealed: 10/18/24 - R310 was admitted to the facility with diagnoses, including but not limited to, chronic obstructive pulmonary disease (COPD) and history of pulmonary embolism (PE). 10/18/24 - E3 (MD) ordered in R310's EMR, "Rivaroxaban oral tablet 20 mg - give one tablet by mouth one time a day for anticoagulant." A known history of PE placed R310 at risk of having her blood clot. The goal of prescribing rivaroxaban was to prevent R310's blood from clotting or to place R310 in a state of anticoagulation. Anticoagulation is not a medical diagnosis; it is a physiologic state. However, R310's medical history included a diagnosis that was a medical indication for the drug rivaroxaban, pulmonary embolism. Therefore, history of PE was the medical diagnosis for R310 requiring the drug, rivaroxaban. "Anticoagulant" was not an adequate indication/ medical diagnosis for the order for R310's rivaroxaban.	F 842	sustained. The following will be a weekly audit x 4 then monthly x 3 months with a goal of 100% achieved and sustained. In an event where compliance is consistently below the goal, the Interdisciplinary Team (IDT) will meet with the QA Committee to review the process, and revision will be made to maintain and sustain compliance. (4) A. The facility cannot retroactively correct the issue r/t R18 and R55. Licensed nurse will be in-serviced by Staff Development/Designee to ensure residents with feeding tubes has appropriate documentation which reflects flushes ordered. R55 was discharged. Unable to correct deficiency. B. Active residents' tube feeding flush orders will be reviewed to ensure staff are documenting accurately the total amount of flushes. C. The root cause was determined to be due to an oversight when documenting tube feeding flushes. Staff Education/Designee will educate licensed nurses and new hires to ensure tube feeding flushes are documented accurately. D. Daily audit by Unit Manager/Designee to ensure licensed nurse to ensure tube feeding flushes are documented accurately x 5 days or until 100%	

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F 842	Continued From page 105 7. Review of R456's clinical record revealed: 10/27/24 - R456 was admitted to the facility with diagnoses, including but not limited to, chronic embolism and thrombosis and hyperlipidemia. 10/327/24 - E3 (MD) ordered in R456's EMR, "Eliquis oral tablet 5 mg (apixaban)- give one tablet by mouth two times a day for anticoagulant therapy." The diagnoses of chronic embolism and thrombosis placed R456 at risk of having her blood clot. The goal of prescribing apixaban was to prevent R456's blood from clotting or to place R456 in a state of anticoagulation. Anticoagulation is not a medical diagnosis; it is a physiologic state. However, R456's medical history of chronic embolism and thrombosis was a medical indication for the drug apixaban. Therefore, chronic embolism and thrombosis was the medical diagnosis for R3456 requiring the drug, apixaban. "Anticoagulant therapy" was not an adequate indication/ medical diagnosis for the order for R456's apixaban. 8. Review of R457 s clinical record revealed: 10/12/24 - R457 was admitted to the facility with diagnoses, including but not limited to, atrial fibrillation and stroke. 10/12/24 - E3 (MD) ordered in R457's EMR, "Apixaban oral tablet 2.5 mg (apixaban) - give one tablet by mouth two times a day for anticoagulation."	F 842	compliance is achieved and sustained. The following will be a weekly audit x 4 then monthly x 3 months with a goal of 100% achieved and sustained. In an event where compliance is consistently below the goal, the Interdisciplinary Team (IDT) will meet with the QA Committee to review the process, and revision will be made to maintain and sustain compliance.	

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F 842	Continued From page 106 Atrial fibrillation placed R457 at risk of having his blood clot. The goal of prescribing apixaban was to prevent R457's blood from clotting or to place R457 in a state of anticoagulation. Anticoagulation is not a medical diagnosis; it is a physiologic state. However, R457's medical history included a diagnosis that was a medical indication for the drug apixaban, atrial fibrillation. Therefore, Afib was the medical diagnosis for R457 requiring the drug, apixaban. "Anticoagulation" was not an adequate indication/ medical diagnosis for the order for R457's apixaban. 11/1/24 3:36 PM - During a telephone interview, C1 (consultant Pharmacist) confirmed that "anticoagulation, anticoagulant therapy, anticoagulant and/or blood thinner" were not medical diagnoses that can be used as an indication for warfarin, rivaroxaban, apixaban or any other novel anticoagulants. 9. Review of R18's clinical record revealed: 11/18/09 - R18 was admitted to the facility. 9/27/24 - R18's MDS documented that R18 had multiple diagnoses including dysphagia (difficulty swallowing), right sided paralysis following a stroke, and had had a feeding tube in place. 10/14/24 - A physician's order was written by E3 (Medical Director) for enteral feed overnight, with a continuous water flush of 52 mls every hour, while the enteral feed was running, for a total of 624 mls every 24 hours.	F 842		

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F 842	Continued From page 107 A review of the November 2024 medication administration record revealed that the enteral feed water flush total amounts for 11/7/24 thru 11/12/24 were not documented. 11/12/24 10:12 AM - During an interview, E15 (RN) confirmed that for R18's enteral feed, the total amount of water flushes on the dates 11/7-11/12 24 inclusive were not recorded. 10. Review of R55's record revealed: 12/13/17 - R55 was admitted to the facility. 9/30/24 - R55's quarterly MDS documented that R55 had multiple diagnoses including dysphagia (difficulty swallowing), left sided paralysis following a stroke and had a feeding tube in place. 10/29/24 - A physician's order was written by E3 (Medical Director) for a 50 ml water flush to be given with the enteral feed, for a total of 1000 mls every 24 hours. A review of the November 2024 medication administration record revealed that the hourly 50 ml water flush was inaccurately documented on the following dates and shifts: 11/1/24 11-7 shift - 400 ml was documented in each hourly water flush column at 1:00 AM and 2:00 AM, instead of the ordered 50 ml per hour 11/1/24 3-11 shift - 400 ml was documented in each hourly water flush column for 4:00 PM thru 10:00 PM, instead of the ordered 50 ml per hour. 11/2/24 3-11 shift - 400 ml was documented in	F 842		

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F 842	Continued From page 108 each hourly water flush column for 4:00 PM thru 6:00 PM instead of the ordered 50 ml per hour. 11/6/24 1:30 PM - During an interview, E4 (LPN) confirmed the incorrect hourly documentation of 50 ml hourly water flushes above. 11. R16's clinical record revealed: 11/5/20 (last reviewed on 6/10/24) - R16 was care planned for potential for skin impairment with an intervention to have nursing staff assist with incontinence care every 2 hours and as needed. 8/13/24 - The quarterly MDS assessment documented that R16 was cognitively intact with a BIMS of 12, frequently incontinent of bladder and required substantial/maximal assistance for toileting hygiene. 11/6/24 at 12:18 PM - During an interview with R16, the resident told the Surveyor that she should receive incontinence care every 2 hours, but this was not being done. Review of the CNA Kardex, as of 11/1/24, documented that R16 was on a "Toileting Program 0500-0600 [5:00-6:00 AM], 0800-0900 [8:00-9:00 AM], 1400-1500 [2:00-3:00 PM], 2100-2200 [9:00-10:00 PM]. While R16's comprehensive care plan documented that the resident was to receive incontinence care every 2 hours, the CNA Kardex stated that R16 was on a toileting program. There was no evidence in R16's comprehensive care plan about a toileting program. The facility failed to ensure R16's CNA Kardex	F 842		

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F 842	Continued From page 109 accurately reflected R16's incontinence care needs. 11/13/24 1:30 PM - Findings were reviewed with E1 (NHA), E2 (DON), E27 (ADON), E47 (RCC), E58 (RDO) and a representative from the Ombudsman office.	F 842		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or	F 880		1/2/25

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F 880	Continued From page 110 infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for seven (R14, R25, R92, R102,	F 880	(1)	

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F 880	Continued From page 111 R120, R314 and R456) out of thirteen residents reviewed for infection control, the facility failed to maintain an infection control program that included enhanced barrier precautions for residents who met the criteria. In addition for R25, high-contact suprapubic care was provided on 10/31/24 without the staff wearing the appropriate PPE. Direct care was provided to R14 on 11/7/24 without the staff wearing appropriate PPE. An environmental tour confirmed several observations of infection control issues. Findings include: Facility's "Infection Prevention and Control Program Policy: This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable disease and infections as per accepted national standards and guidelines." (revised 1/2024) Facility's "Enhanced Barrier Precautions Policy: It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multi-drug-resistant organisms (MDRO) ...Policy Explanation and Compliance Guidelines: 2. Initiation of Enhanced Barrier Precautions- a. Nursing staff may place residents with certain conditions or devices on enhanced barrier precautions empirically while awaiting physician orders. B. An order for enhanced barrier precautions will be obtained for residents with any of the following: i. wounds ... and/or indwelling medical devices (e.g. central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes) even if the resident is not known to be infected or colonized with a MDRO ... 4. High-contact resident care	F 880	A. R25's order was revised to reflect EBP and nurse E26 will be educated regarding EBP and PPE requirement during care R92's order was revised to reflect EBP. R102 is no longer in the facility. Unable to correct the deficiency. R120 is no longer in the facility. The facility cannot retroactively correct the issue. R314 is no longer in the facility. The facility cannot retroactively correct the issue. R456 is no longer in the facility. The facility cannot retroactively correct the issue. R14's order was revised to reflect EBP. E67, E69, E71 will be educated regarding PPE requirement for residents meeting EBP criteria and supplies are accessible to staff. B. Active residents meeting the requirement for EBP will be reviewed to ensure EBP order is in place. Staff will be educated regarding EBP process and PPE requirement. Staff will be educated regarding access to EBP supplies. C. The root cause was determined to be	

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F 880	Continued From page 112 activities include: ... g. device care ... 6. Enhanced barrier precautions should be used for the duration of the affected resident's stay in the facility or until the wound heals or indwelling medical device is removed.". 1. Review of R25's clinical record revealed: 7/9/24- R25 was admitted to the facility with diagnoses, including but not limited to obstructive and reflux uropathy and suprapubic catheter in situ (in place). 7/9/24- E3 (MD) ordered in R25's electronic medical record (EMR), "Cleanse suprapubic catheter site with NSS (normal saline solution), pat dry. Apply 4x4 gauze daily one time a day." 8/22/24 - E3 (MD) ordered in R25's EMR, "Enhanced Barrier Precautions: related to suprapubic cath. 1. Gown. 2. Mask 3. Face shield (if splattering expected to occur) 4. Gloves every shift." 11/4/24 10:35 AM - Review of R25's order recap report lacked evidence of an order for enhanced barrier precautions during R25's admission from 7/9/24 until 8/22/24 despite R25 meeting criteria for enhanced barrier precautions by having an indwelling medical device. The facility failed to order and implement enhanced barrier precautions with R25 spending 46 days in the facility with an indwelling device (suprapubic catheter) without staff practicing enhanced barrier precautions during high-contact care activities for R25. 10/31/24 10:09 AM - Surveyor observed E26	F 880	due to lack of consistent follow-through when a resident is admitted, or a condition arises requiring EBP. The root cause was determined to be due to staff's lack of understanding regarding EBP process and PPE requirement and lack of oversight to ensure PPE supplies are readily available for use. Staff Development/Designee will educate licensed nurses to ensure residents meeting the criteria for EBP have an order in place in a timely manner. Daily in morning meeting, new admissions/readmissions and new cases requiring EBP will be reviewed to ensure an order is in place. Staff Development/Designee will educate nursing and therapy staff regarding PPE requirements when a resident is on EBP and availability of supplies. D. Daily audit by Unit Manager/Designee to ensure residents meeting the criteria for EBP has an order is in place x 5 days or until 100% compliance is achieved and sustained. The following will be a weekly audit x 4 then monthly x 3 months with a goal of 100% achieved and sustained. In an event where compliance is consistently below the goal, the Interdisciplinary Team (IDT) will meet with the QA Committee to	

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F 880	Continued From page 113 (LPN) change the dressing on R25's suprapubic catheter without donning a gown. R25's suprapubic catheter care is a high-contact resident care activity and a gown should have been worn during this care. 2. Review of R92's clinical record revealed: 7/24/24 - R92 admitted to the facility with diagnoses, including but not limited to, calculus (stone) of the bile duct with acute cholecystitis with obstruction. 7/24/24 - E51 (NP) ordered in R92's EMR, "Change the cholecystostomy tube drain dressing with gauze and tape every 5 days and PRN as needed if dressing is soiled or wet AND one time a day every 5 days." 7/28/24 - E52 (NP) ordered in R92's EMR, "Flush cholecystostomy drain with 10 mls (milliliters) NS (normal saline) daily one time a day for cholecystitis." 11/4/24 9:46 AM - Review of R92's order recap report lacked evidence of an order for enhanced barrier precautions since R92 's admission on 7/24/24. The facility failed to order and implement enhanced barrier precautions for R92 spending 103 days in the facility with an indwelling device (cholecystostomy tube) without staff practicing enhanced barrier precautions during high-contact care activities. 3. Review of R102's clinical record revealed:	F 880	review the process, and revision will be made to maintain and sustain compliance. Daily observational audit by Staff Development/Designee to ensure staff are compliant with PPE requirement when a resident is on EBP and supplies are readily available x 5 days or until 100% compliance is achieved and sustained. The following will be a weekly audit x 4 then monthly x 3 months with a goal of 100% achieved and sustained. In an event where compliance is consistently below the goal, the Interdisciplinary Team (IDT) will meet with the QA Committee to review the process, and revision will be made to maintain and sustain compliance. (2) A. R14 Styrofoam device utilized on bed frame was reviewed to assure infection control measures could be maintained. B. Residents with current foam padding on bed frame was reviewed to assure infection control measures could be maintained. C. The root cause was determined to be due to lack of thorough understanding regarding infection control impact of current foam padding. Staff Development/Designee will educate nursing and Maintenance Department regarding use of padding material that can be washed or cleaned to assure infection control measures could	

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	085004	A. BUILDING _____ B. WING _____	C 11/15/2024

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F 880	Continued From page 114 8/30/23 - R102 admitted to the facility with diagnoses, including but not limited to, end stage renal disease with dependence on hemodialysis. 12/27/23 - E3 (MD) ordered in R102's EMR, "Type of access for dialysis and location: Hemodialysis right chest wall ...". 4/1/24 - Centers for Medicare & Medicaid Services (CMS) Enhanced Barriers in Nursing Homes regulation becomes effective. 4/27/24 - E3 (MD) placed R102's order, "Type of access for dialysis and location: Hemodialysis right chest wall ..." on hold in the EMR. 4/27/24 to 5/21/24 - R102 was hospitalized. 5/21/24 - R102 re-admitted to the facility. 8/27/24 to 9/14/24 - R102 was hospitalized. 9/17/24 - E3 (MD) ordered in R102's EMR, "Type of access for dialysis and location: Hemodialysis right chest wall ...". 9/20/24 to 9/22/24 - R102 was admitted to the hospital. 9/22/24 - R102 was re-admitted back to the facility. 11/7/24 12:59 PM - Review of R102's order recap report lacked evidence of an order for enhanced barrier precautions since 4/1/24. 4. Review of R120's clinical record revealed: 5/31/24 - R120 was admitted to the facility with	F 880	be maintained. D. Daily audit by Maintenance Director/Designee to ensure paddings are made of washable and able to clean materials 5 days or until 100% compliance is achieved and sustained. The following will be a weekly audit x 4 then monthly x 3 months with a goal of 100% achieved and sustained. In an event where compliance is consistently below the goal, the Interdisciplinary Team (IDT) will meet with the QA Committee to review the process, and revision will be made to maintain and sustain compliance. (3) A. R41's bathroom was checked, and each resident's basins were replaced, labeled and stored appropriately when not in use. B. Active residents' bathroom and bath basins will be checked, labeled and will be stored appropriately when not in use. C. The root cause was determined to be lack of process with labeling and storing bath basins when not in use. Staff Development/Designee will in-service nursing staff, and new hires to ensure bath basins are labeled and stored appropriately when not in use. D. Daily audit by Unit Manager/Designee to ensure bath basins are labeled and stored appropriately when not in use 5	

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F 880	Continued From page 115 diagnoses, including but not limited to, heart failure and rectal cancer. 5/31/24 - E51 (NP) ordered in R120's EMR, "PICC (peripherally inserted central catheter) ... flush with 5-10 ml (milliliters) ...". R120's PICC line was an indwelling medical device and enhanced barrier precautions should have been initiated. 6/22/24 - R120 was discharged from the facility to home. 11/7/24 4:22 PM - Review of R120's order recap report lacked evidence of an order for enhanced barrier precautions during R120's 5/31/24 to 6/22/24 admission. 5. Cross refer F881, example 3 Review of R314's clinical record revealed: 10/23/24 - R314 admitted to the facility with diagnoses including but not limited to, stroke and chronic osteomyelitis. 10/23/24 - E51 (NP) ordered in R314's EMR, "Foley cath (catheter) care q (every) shift ...". R314's foley catheter qualified as an indwelling medical device and R314 should have been placed on enhanced barrier precautions. 10/25/24 - E3 (MD) documented in R314's admission history and physical, " ...He [R314] does have a left foot wound that he is being treated for osteomyelitis from podiatry ...He is now on meropenem through November 7 ... He	F 880	days or until 100% compliance is achieved and sustained. The following will be a weekly audit x 4 then monthly x 3 months with a goal of 100% achieved and sustained. In an event where compliance is consistently below the goal, the Interdisciplinary Team (IDT) will meet with the QA Committee to review the process, and revision will be made to maintain and sustain compliance.	

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F 880	Continued From page 116 does have a foley catheter placed ...". 11/11/24 4:41 PM - Review of R314's order recap report lacked evidence of an order for enhanced barrier precautions since R314's admission on 10/23/24. 6. Review of R456's clinical record revealed: 10/27/24 - R456 was admitted to the facility. 10/28/24 - E3 (MD) ordered in R456's EMR, "Change suprapubic catheter ...". R456's suprapubic catheter was an indwelling medical device and enhanced barrier precautions should have been initiated. 11/4/24 10:04 AM - During an interview, R456 confirmed that she had a suprapubic catheter. 11/4/24 9:40 AM - Review of R456's order recap report lacked evidence of an order for enhanced barrier precautions during R456's admission. 11/12/24 3:15 PM - During an interview, E4 (LPN/IP) stated, "Just trying to be transparent, we did miss ordering EBP (enhanced barrier precautions) for R102, R456 and R92 ." 7. Review of R14's clinical record revealed: 9/5/24 at 2:17 PM - A progress note by E51 (NP) documented that R14 had a wound to the left lower extremity and returned from the hospital with sutures. Review of R14's EHR revealed that there was no enhanced barrier precaution (EBP) physician's	F 880		

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F 880	Continued From page 117 order for the significant wound. However, there was an active EBP physician's order, dated 12/12/23, for ESBL in the urine. 11/6/24 - Review of the CNA Kardex for R14 lacked evidence to use EBP when providing R14 direct care. 11/7/24 at 4:50 AM - Surveyor observation of R14's nameplate outside her room indicated an orange sticker next to her name. Surveyor observed incontinence care provided by E67 (CNA) at this time. R14 still had the wound. E67 did not apply a gown prior to providing incontinence care to R14. Surveyor also observed that no PPE (gown, mask) were placed in the resident's room for staff to don before providing direct care. 11/7/24 at 5:40 AM - During an interview, Surveyor asked E69 (RN, Night shift Supervisor) standing outside R14's room what the orange sticker next to her name represented. E69 replied, "I am going to check" and walked away from the Surveyor back to the nurse's station. 11/7/24 at 5:41 AM - During a combined interview with E67 (CNA) and E68 (CNA), Surveyor asked each CNA what the orange sticker next to R14's name represented. E68 stated it is "for precautions and PPE is behind the door." E67 stated that she did not know. 11/7/24 at 5:45 AM - During a follow-up interview, E69 returned to the Surveyor, who was still standing outside R14's room in the hallway. E69 stated that the orange sticker was for EBP. E69 stated that she was not sure if precautions were needed when providing direct care as R14's	F 880		

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F 880	Continued From page 118 wound is covered. Immediately confirmed with E69 that there was no PPE available in R14's room for staff to use. 11/7/24 at 8:21 AM - Surveyor observed R14's scheduled shower with E9 (LPN) and E71 (CNA). E9 removed R14's wound dressing and was wearing appropriate PPE. However, E71 only wore gloves and showered R14. 11/7/24 at approximately 8:45 AM - Findings were reviewed with E4 (LPN/QA/IC). 8. On 11/7/24 from 3:42 PM to 4:10 PM, an environmental tour was conducted with E17 (Regional Maintenance Director) and E18 (Environmental Services Director). The following were reviewed and confirmed. - R14's bed frame and left sided quarter bed rail was covered with a gray styrofoam that could not be cleaned properly. - R41's shared bathroom had two uncovered plastic wash bins sitting directly on the stained and dusty floor. - Surveyor reviewed with E17 as R67's room was inaccessible at the time that the resident also had gray styrofoam padding on the right sided grab bar too. E17 acknowledged this finding and would take care of it. 11/13/24 1:30 PM - Findings were reviewed with E1 (NHA), E2 (DON), E27 (ADON), E47 (RCC), E58 (RDO) and a representative from the Ombudsman office.	F 880		
F 881 SS=E	Antibiotic Stewardship Program	F 881		1/2/25

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F 881	Continued From page 119 CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for three (R147, R307 and F606) out of twenty-one residents reviewed for antibiotic stewardship, the facility failed to ensure that antibiotics were prescribed in accordance with recognized standards. For R606 the facility also failed to ensure the antibiotic was placed on the line list. Findings include: Facility's "Infection Prevention and Control Program Policy:... 3. Surveillance: a. A system of surveillance for prevention, identifying, reporting, investigating and controlling infections and communicable diseases for all residents... based on national standards... 6. Antibiotic Stewardship: b. Antibiotic use protocols and a system to monitor antibiotics use will be implemented as part of the antibiotic stewardship program." (revised 1/2024) McGeer's Criteria for Infection Surveillance: Syndrome - UTI with indwelling catheter Criteria- Must fulfill both 1 and 2. 1. At least one of the following sign or symptom: - fever, rigors, or new onset hypotension, with no alternate site of infection	F 881	A. R147 had been discharged. The facility cannot retroactively correct the issue R307 has no adverse effect related to the deficiency. Antibiotic use was discussed with the in-house providers. R606 had been discharged. The facility cannot retroactively correct the issue. B. Active residents receiving antibiotics in the last 5 days will be reviewed to ensure antibiotic use meets Mcgreer's criteria and reflected online list. C. The root cause was determined to be due to lack of thorough understanding of the antibiotic stewardship process. Staff Development/Designee will educate IP and licensed nurses regarding the antibiotic stewardship policy. Medical Director/Designee will educate providers regarding antibiotic stewardship and the Mcgreer criteria.	

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F 881	Continued From page 120 - either acute change in mental status or acute functional decline, with no alternate diagnosis and leukocytosis - new-onset suprapubic pain or costovertebral angle pain or tenderness - purulent discharge from around the catheter or acute pain, swelling, or tenderness of the testes, epididymis, or prostate 2. Urinary catheter specimen culture with > or = 105 cfu/ml of any organism(s) 1. Review of R147's clinical record revealed: 9/10/24 - R147 was admitted to the facility with diagnoses, including but not limited to, bladder cancer. 9/27/24 - E3 (MD) ordered in R147's EMR, "20-24 French Coude catheter for obstructive uropathy...". 10/16/24 - E52 (NP) ordered in R147's EMR, "Cephalexin oral capsule 500 mg (milligrams) - give 1 capsule by mouth two times a day for UTI until 10/23/24. Administer x 7 days." 10/18/24 2:05 PM - E52 discontinued the cephalexin order in R147's EMR. 10/18/24 - E52 (NP) ordered in R147's EMR, "Levaquin oral tablet 500 mg (levofloxacin)- give 1 tablet by mouth one time a day for (sic) administer X 7 days until 10/26/24." 11/11/24 2:35 PM - Review of R147's EMR lacked evidence of a urine culture specimen order or results for R147 at any time around 10/14 to 10/26/24.	F 881	D. Daily audit by Medical Directo/Designee to ensure infection meets the Mcgreer criteria before prescribing antibiotic x 5 days or until 100% compliance is achieved and sustained. The following will be a weekly audit x 4 then monthly x 3 months with a goal of 100% achieved and sustained. In an event where compliance is consistently below the goal, the Interdisciplinary Team (IDT) will meet with the QA Committee to review the process, and revision will be made to maintain and sustain compliance.	

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F 881	Continued From page 121 11/12/24 3:15 PM - During an interview, E4 (LPN/IP) stated, "Just trying to be transparent... for [R147], I have no idea why the NP (nurse practitioner) put him on cephalexin and Levaquin. We don't have a urine. I asked several times and never got a response." 2. Review of R307's clinical records revealed: 10/24/24 - R307 re-admitted to the facility from the hospital. R307's Interagency Discharge Orders documented R307 as being admitted to the hospital for a catheter- associated urinary tract infection and also stated that R307 has a chronic indwelling foley catheter. 10/30/24 1:48 PM - During an interview, E4 confirmed that he was the facility's Infection Preventionist. He stated that the facility utilized the McGeer Criteria for Infection Surveillance to promote antibiotic stewardship. 11/6/24 - E52 (NP) ordered in R307's EMR, "UA (urinalysis) and C&S (culture & sensitivities)... for infection...". 11/8/24 1:43 PM - R307's urine culture results were received at the facility stating "1 Organism growth". 11/8/24 - E52 (NP) ordered in R307's EMR, "Cipro oral tablet 500 mg- give 1 tablet by mouth every 12 hours for infection until 11/16/24." 11/12/24 - The facility was not able to produce evidence of R307's 11/6/24 urine culture final microbiology report with sensitivity for the	F 881		

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F 881	Continued From page 122 surveyor to review because they were "awaiting final culture read". Without the final microbiology culture read with the cfu/ml numbers, R307 did not meet McGeer's Criteria for Infection Surveillance for UTI with indwelling catheter. 3. Review of R606's record revealed: 1/25/24 11:58 AM - A physician progress note documented R606 as having "Recent fever History Of Present Illness:... here for long-term care was to be discharged to assisted living yesterday [on 1/24/24]. Resident [R606] developed fever and shaking. Resident was given 1 g Rocephin [antibiotic]. Resident seen this morning sitting in his wheelchair no acute distress. Resident appears back to baseline. Resident reports he is slightly anxious." 1/25/2024 11:15 AM - A physicians order for R606 to inject 1 gram of CefTRIAXone Sodium Solution an antibiotic intramuscularly one time for COPD exacerbation for one day. 11/7/24 11:55 AM - Review of the January line list lacked evidence of R606's antibiotic and what infection R606 was being treated for with Rocephin 1 gram. Also, the facility lacked evidence of laboratory or radiology reports to confirm what infection. 11/08/24 10:17 AM - A brief interview with E3 (MD) revealed that sometimes a one time dose of IM CefTRIAXone (antibiotics) is given if a resident is sick enough. It was further revealed the length of time it takes to get the lab test or a chest xray for confirmation it could be later at night or the	F 881		

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F 881	Continued From page 123 next day. 11/13/24 1:30 PM - Findings were reviewed with E1 (NHA), E2 (DON), E27 (ADON), E47 (RCC), E58 (RDO) and a representative from the Ombudsman office.	F 881		
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure	F 883		1/2/25

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F 883	Continued From page 124 that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for four (R15, R33, R102 and R138) out of eight residents reviewed for vaccines, the facility failed to have evidence in each resident's medical record the administration of the influenza and/or pneumococcal vaccines. Findings include: Facility's Infection Prevention and Control Program- "... 7. Influenza and Pneumococcal Immunization:... b. Residents will be offered the pneumococcal vaccines recommended by the CDC (Center for Disease Control) upon admission, unless contraindicated or received the	F 883	A. R15 was offered pneumococcal vaccine. R33 had been discharged. The facility cannot retroactively correct the issue R102 had been discharged. The facility cannot retroactively correct the issue. R138 _was reviewed to assess whether resident received or was offered pneumococcal vaccine. B. Active residents will be reviewed to assure medical record reflects documentation of acceptance or	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 883	Continued From page 125 vaccines elsewhere... e. Documentation will reflect the education provided and details regarding whether or not the resident received the immunizations." (revised 1/2024) 1. Review of R15's clinical record revealed: 9/20/23 - R15, aged 87 years, was admitted to the facility. 9/20/23 - E3 (MD) documented an order to "give pneumococcal vaccine IM (intramuscularly)." 10/30/24 10:35 AM - Review of R15's electronic medical record (EMR) revealed that no pneumococcal vaccine was offered to R15. The facility failed to offer R15 the pneumococcal vaccine. 2. Review of R33's clinical record revealed: 9/30/24 - R33, aged 70 years, was admitted to the facility. 10/30/24 10:35 AM - Review of R33's EMR lacked evidence that the pneumococcal vaccine was up-to-dated or offered. 10/30/24 11:00 AM - Review of the DELVAX website, the State of Delaware public immunization portal, revealed R33 as having received PPV23 on 5/21/16, PCV13 on 1/23/19 and PCV20 on 6/17/22. This series of vaccines reflected a complete pneumococcal vaccine schedule; however, R33's EMR failed to include the documentation of R33's pneumococcal immunization status.	F 883	declination of Influenza and Pneumonia vaccines. C. The root cause was determined to be due to lack of consistent oversight to ensure immunizations are offered consistently and administered as indicated and documented in the EMR. Staff Development/Designee will educate admissions / IP and licensed nurses on the importance of offering Influenza and Pneumonia vaccines per guidelines. Infection Preventionist/Designee will monitor new admissions, readmissions and quarterly resident's immunization status and to ensure it is reflected in the medical records. D. Daily audit by Infection Preventionist/Designee to ensure immunization status is current and documented in the EMR x 5 days or until 100% compliance is achieved and sustained. The following will be a weekly audit x 4 then monthly x 3 months with a goal of 100% achieved and sustained. In an event where compliance is consistently below the goal, the Interdisciplinary Team (IDT) will meet with the QA Committee to review the process, and revision will be made to maintain and sustain compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085004	A. BUILDING _____ B. WING _____	C 11/15/2024

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F 883	Continued From page 126 3. Review of R102's clinical record revealed: 8/30/23 - R102, aged 68 years, admitted to the facility. 10/30/24 10:35 AM - Review of R102's EMR revealed that no pneumococcal vaccine was documented for R102. 10/30/24 11:00 AM - Review of the DELVAX website revealed R102 as having received PCV20 on 10/5/23. R102's EMR failed to include the documentation of R102's pneumococcal immunization status. 4. Review of R138's clinical record: 8/1/24 - R138, aged 75 years, was admitted to the facility. 10/30/24 10:35 AM - Review of R138's EMR revealed no pneumococcal vaccine for R138 or that she had refused the vaccine. 10/30/24 11:00 AM - Review of the DELVAX website revealed R138 as having received PCV13 on 4/2/18. Per the CDC adult Pneumococcal vaccine schedule, R138 was due for PCV20 upon admission to the facility. The facility was not able to provide evidence of R138's declination of the pneumococcal vaccine. 10/31/24 11:40 AM - During an interview, E4 (Infection Preventionist) confirmed that the facility had not held a vaccine clinic last year. "The last IP (Infection Preventionist) had not kept up with it but we are trying to get back on track." E4 confirmed that R15 had not had a pneumococcal vaccine but her family consented to give it to her	F 883		

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F 883	Continued From page 127 at the upcoming vaccine clinic. E4 confirmed that R33, R102 and R138 all had pneumococcal vaccines documented in DELVAX but not in the facility's EMR. 11/13/24 1:30 PM - Findings were reviewed with E1 (NHA), E2 (DON), E27 (ADON), E47 (RCC), E58 (RDO) and a representative from the Ombudsman office.	F 883		
F 887 SS=D	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any	F 887		1/2/25

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F 887	Continued From page 128 additional doses; (v) The resident, resident representative, or staff member has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident; or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for two (R25 and R33) out of eight residents reviewed for vaccines, the facility failed to record R25 and R33's COVID vaccines in their medical records. Findings include: Facility's Infection Prevention and Control program- "... COVID-19 Immunization:... f. Documentation will reflect the education provided	F 887	A. R25's COVID vaccine immunization history had been updated in the EMR. Resident was offered COVID 24/25 immunization. R33 had been discharged. The facility cannot retroactively correct the issue.	

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F 887	Continued From page 129 and details regarding whether or not the resident or staff received the vaccine." (revised 1/2024) 1. Review of R25's clinical record revealed: 7/9/24 - R25, aged 81 years, was admitted to the facility. 10/30/24 10:35 AM - Review of R25's electronic medical record (EMR) revealed no COVID-19 vaccines were documented as administered to R25. 10/30/24 11:00 AM - Review of the DELVAX website, the State of Delaware public immunization portal, revealed R25 as having received the COVID-19 vaccine on the following dates: 2/17/21, 3/17/21, 12/15/21 and 8/15/22. The facility was unable to provide evidence of R25's education and declination of the COVID vaccine. 2. Review of R33's clinical record revealed: 10/30/24 10:35 AM - Review of R33's EMR revealed no COVID-19 vaccines were documented as administered to R33. 10/30/24 11:00 AM - Review of the DELVAX website revealed R33 as having received the COVID-19 vaccine on the following dates: 11/19/21, 10/4/22 and 10/13/23. The facility was unable to provide evidence of R33's education and declination of the COVID vaccine. 10/31/24 11:40 AM - During an interview, E4	F 887	B. Current resident's COVID-19 status will be reviewed and revised in the EMR. Residents who are not up to date or declined in the past will be offered the current COVID-19 vaccine as per CDC guideline. Residents with declination will have evidence of education provided on benefits and potential risk C. The root cause was determined to be due to lack of consistent oversight and follow-through when a resident is admitted ensuring vaccination status is entered in the EMR and if declining the vaccine proof of education regarding benefits and potential risks. Staff Development/Designee will educate licensed nurse regarding COVID-19 vaccination and the importance of providing education of the benefits and potential risk and assuring documentation in the EMR. D. Daily audit by Infection Preventionist /Designee will be conducted to ensure new admission's COVID-19 vaccination information is reflected in the EMR including education of benefits and potential risk x 5 days or until 100% compliance is achieved and sustained. Following will be a weekly audit x 4 then monthly x 3 months with a goal of 100% achieved and sustained. In an event where compliance is consistently below the goal, the Interdisciplinary Team (IDT) will meet with the QA Committee to review the process, and revision will be made to maintain and sustain compliance.	

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F 887	Continued From page 130 (Infection Preventionist) confirmed that the facility had not held a vaccine clinic last year. "The last IP (Infection Preventionist) had not kept up with it but we are trying to get back on track." E4 confirmed that R25 and R33 had received COVID-19 vaccines that were documented in DELVAX but not in the facility's EMR. 11/13/24 1:30 PM - Findings were reviewed with E1 (NHA), E2 (DON), E27 (ADON), E47 (RCC), E58 (RDO) and a representative from the Ombudsman office.	F 887		