

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/13/2019
FORM APPROVED
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085039 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 07/23/2019 |
| NAME OF PROVIDER OR SUPPLIER NEW CASTLE HEALTH AND REHABILITATION CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 32 BUENA VISTA DRIVE NEW CASTLE, DE 19720 | |
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| E 000 | Initial Comments An unannounced Emergency Preparedness survey was conducted at this facility beginning July 11, 2019 to July 23, 2019 by the State of Delaware Division of Health Care Quality, Office of Long Term Care Residents Protection in accordance with 42 CFR 483.73. The facility census the first day of the survey was 107. For the Emergency Preparedness survey, all contracts, operations plan, contact information, and annual emergency drills were up to date. No deficiencies were identified. | E 000 | | |
| F 000 | INITIAL COMMENTS An unannounced annual, complaint, emergency preparedness, and extended surveys were conducted at this facility from July 11, 2019 to July 23, 2019. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census the first day of the survey was 107. The survey sample size was 45. Abbreviations/Definitions used in this report are as follows: Accucheck - a brand name for glucometer; ADL -activities of daily living; Anoxic brain damage - type of brain injury that occurs when the brain is deprived of oxygen; Aspiration - inhaling fluid or food into the lungs; AV fistula - An arteriovenous fistula (AV fistula) is the connection of a vein and an artery, usually in the forearm, to allow access to the vascular system for hemodialysis, a procedure that performs the functions of the kidneys in people | F 000 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

08/19/2019

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

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| F 000 | <p>Continued From page 1 whose kidneys have failed; BIMS (Brief Interview for Mental Status) - test to measure thinking ability with score ranges from 00 to 15. 13-15: Cognitively intact 08-12: Moderately impaired 00-07: Severe impairment CNA - Certified Nurse's Aide; Cerebral Vascular Accident (CVA) - (Stroke) a condition involving reduced blood supply to the brain from intracerebral hemorrhage, thrombosis, embolism, or vascular insufficiency; Cognitively intact - an individual who has a correct mental train of thought; DA - Dietary Aide; DON - Director of Nursing; Dysphagia - a disorder in swallowing OR difficulty swallowing; End-Stage Renal Disease - (ESRD) disease where the kidneys stop working; Enteral - administration is food or drug via the human gastrointestinal tract; Extubation - The process of removing a tube from a hollow organ or passageway, often from the airway and may be at times accidental/unplanned; FEES - Fiberoptic Endoscopic Evaluation of Swallowing (swallowing evaluation that assess areas surrounding the voice box and opening of the esophagus, through the use of a small flexible telescope); Gastrostomy - surgical construction of a permanent opening from the outside surface of the abdominal wall into the stomach, usually for inserting a feeding tube; Glucometer - a machine used for testing blood sugar in the bloodstream; G-tube (Gastric Tube) - a tube is passed into a patient's stomach through the abdominal wall,</p> | F 000 | | |

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| F 000 | <p>Continued From page 2</p> <p>most commonly to provide a means of feeding when oral intake is not adequate;</p> <p>Hemodialysis - procedure that removes waste and extra fluid from the body through the blood;</p> <p>Hemiparesis - the unilateral weakness of the entire left or right side of the body;</p> <p>HSKG - Housekeeping;</p> <p>Hypoxia - a condition in which the body or a region of the body is deprived of adequate oxygen supply at the tissue level;</p> <p>Inner cannula - A cannula is a hollow piece of tubing used for medical purposes. It usually has an inner tube, and an outer tube, called the outer cannula. These tubes may be used for breathing from an opening in the neck;</p> <p>Jejunostomy - surgical creation of an opening through the skin;</p> <p>J-tube - a feeding tube which is inserted into the patient's jejunum (small intestine);</p> <p>L-oxygen provided by oxygen concentrators are measured in LPM (liters per minute) for continuous flow.</p> <p>lbs- pounds- measurement of weight;</p> <p>L/M - Liters per minute;</p> <p>LPN - Licensed Practical Nurse;</p> <p>ML - milliliter - unit of volume;</p> <p>MR - Medical Records;</p> <p>MDS - Minimum Data Set (standardized assessment forms used in nursing homes);</p> <p>NC (Nasal Cannula)-a device used to deliver supplemental oxygen or increased airflow to a patient or person in need of respiratory help;</p> <p>NP- Nurse Practitioner;</p> <p>O2-oxygen;</p> <p>Oxygen saturation - Oxygen saturation refers to the level of oxygen carried by red blood cells through the arteries and delivered to internal organs.</p> <p>Offload heels - A process of elevating the heels</p> | F 000 | | |

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| F 000 | Continued From page 3 off of the bed to reduce pressure on the heels and to prevent "bed sores"; NHA- Nursing Home Administrator; O2-oxygen; Passy-Muir Valve - a speaking valve which is commonly used to help individuals speak more normally. When the individual breathes out, the valve closes and air flows around the tracheostomy tube, up through the vocal cords allowing sounds to be made; PRN - As needed; PROM - Passive Range of Motion- the extent to which a joint can be moved safely with staff OR done by staff; Quadriplegia - paralysis of arms and legs; RDCS - Regional Director of Clinical Services; RN - Registered Nurse; RRT - Registered Respiratory Therapist; Seizure - abnormal electrical activity in the brain causing repetitive muscle jerking; Spastic hemiplegia - a neuromuscular condition of spasticity that results in the muscles on one side of the body being in a constant state of contraction; Stoma - an artificial opening made into a hollow organ, especially one on the surface of the body leading to the gut or trachea; Tracheostomy-(trach)- an opening surgically created through the neck into the trachea (windpipe) to allow direct access to the breathing tube; a tube is usually placed through this opening to provide an airway and to remove secretions from the lungs; breathing is done through the tracheostomy tube rather than through the nose and mouth; Traumatic Brain Injury - when a bump, blow, jolt, or other head injury causes damage to the brain; Tunneled Dialysis Catheter - a catheter that contains two lumens: venous and arterial and is | F 000 | | | |

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| F 000 | Continued From page 4 used for exchanging blood to and from a hemodialysis machine and a patient; #- Pound- measurement of weight #4 Shiley - type and size of a tracheostomy tube. | F 000 | | | |
| F 656 SS=E | Develop/Implement Comprehensive Care Plan 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 | F 656 | | 8/22/19 | |

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| F 656 | <p>Continued From page 5</p> <p>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.</p> <p>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interviews and record review it was determined that for 4 (R51, R69, R94, and R102) out of 45 sampled residents reviewed for care plans, the facility failed to initiate a person-centered comprehensive care plan. For R51, the facility failed to include the resident's preference to assist with his tracheostomy care. For R69 the facility failed to chart behaviors every shift. For R94 the care plan did not include a physician's ordered intervention to offload his/her heels and lacked a care plan for refusals. For R102, the facility failed to include R102's size and style of the tracheostomy tube and the specific risks for complications....Findings include:</p> <p>The following was reviewed in R51's clinical record:</p> <p>1. 12/6/18 - R51 was admitted to the facility with a diagnosis of traumatic brain injury related to a history of a gun shot wound and resultant tracheostomy dependence.</p> <p>5/28/19 - A quarterly MDS documented that R51 was cognitively intact and was extensive assist for activities of daily living.</p> | F 656 | <p>Preparation and submission of this Plan of Correction does not constitute an admission of or agreement with, it is required by State and Federal Law. It is executed and implemented as a means to continuously improve the quality of care to comply with State and Federal requirements.</p> <p>F656E - Develop /Implement Comprehensive Care Plan</p> <p>Step 1:</p> <p>R51 care plan was updated to reflect resident s preference to assist with trach care.</p> <p>R69 behavior monitoring sheet and care plan was updated to reflect residents current behaviors of verbal aggression towards staff and noncompliance and non compliance with care.</p> <p>Resident 94 care plan updated to reflect refusal to offload heels and turned and repositioned.</p> <p>Resident 102 has been discharged from the facility.</p> <p>Step 2:</p> <p>Residents requiring tracheostomy care</p> | | |

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| F 656 | <p>Continued From page 6</p> <p>7/17/19 1:20 PM - During an observation and interview with E8 (RN) it was revealed that R51 preferred to assist with his/her tracheostomy care. E8 stated, "R51 has less anxiety when [he/she] assists." R51 mouthed, "I want to do it." During the procedure, R51 demonstrated that he/she was able to assist E8 by removing the soiled inner cannula and inserting a clean inner cannula. R51 was also able to dry the stoma with guaze after E8 had cleaned it with saline. E8 kept the procedure as clean as he/she could while allowing R51 to assist with tracheostomy care and honoring his/her preferences. R51 did not exhibit any anxious expressions throughout the procedure. R51 smiled and nodded when the procedure was complete.</p> <p>R94's care plan lacked evidence that R51 was able to, and preferred to be, as independent with his/her tracheostomy care as possible.</p> <p>The facility failed to initiate a comprehensive care plan to include R51's specific preference to assist with his/her own tracheostomy care.</p> <p>2. The following was reviewed in R94's clinical record:</p> <p>3/19/19 - R94 was admitted to the facility with a history of a stroke.</p> <p>6/8/19 - A physician's order included to offload heels while in bed.</p> <p>6/17/19 - A quarterly MDS documented that R94 was moderately cognitively impaired and required extensive assistance of two staff members for bed mobility.</p> | F 656 | <p>have the potential to be affected. The Director of Nursing (DON) and/or designee will audit care plans of residents with tracheostomies to ensure they reflect preference to assist with trach care, as necessary. Care plans will also be reviewed to ensure that trach type, size, and specific risks for complication; including mucous plug and obstructed airway, are present. Where necessary the care plan was updated.</p> <p>Residents requiring assisted turn and repositioning while in bed; or have their heels off loaded, have the potential to be affected. The DON and/or designee will complete an audit of current residents with care refusals and will then ensure their care plan reflects this behavior. Where necessary the care plan was updated.</p> <p>Residents with demonstrating verbal aggression and/or non compliance with care have the potential to be affected. The DN and/or designee will review residents with behaviors to ensure their Behavior Flow sheet reflects their plan of care. Where necessary the care plan was updated.</p> <p>Step 3: To prevent the potential for reoccurrence the DON and/or designee will educate licensed nursing staff to on the development of comprehensive care plans with emphasis on behaviors (noncompliance, noncompliance with care, verbal aggression), tracheostomies, and artificial airway complications.</p> | | |

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| F 656 | <p>Continued From page 7</p> <p>7/16/19 - R94's revised skin integrity care plan did not include the physician's ordered intervention to offload R94's heels, nor did it address his/her refusals of heels being offloaded and being turned and repositioned.</p> <p>6/27/19 - In a progress note it was documented that R94 continued to be treated for an unstageable deep tissue injury of the right heel.</p> <p>7/18/19 2:11 PM - In an interview and observation with E33 (CNA) he/she reported that R94 has some discomfort with repositioning. E33 stated that R94 had a positioning device to elevate his/her heels, but "[he/she] does not like it." The positioning device was pointed at by E33 and available for use. E33 reported that R94 did have an area on his/her right heel that was "dark". R94 refused for E33 to turn him/her on his/her side or to offload his/her heels.</p> <p>7/22/19 12:40 PM - In an interview with E32 (CNA) it was reported that R94 would tell you what he/she wants regarding his/her care and positioning. E32 was able to assist R94 to straighten out his/her right leg (which would allow for heels to be offloaded), but R94 refused to have heels offloaded. E32 stated that R94 is "particular about what [he/she] wants."</p> <p>7/22/19 1:09 PM - In an interview with E1 (NHA) he/she stated that residents should be care-planned for refusals of care.</p> <p>7/22/19 1:13 PM - In an Interview with E34 (CNA) it was reported that R94 often refused to have heels offloaded in bed.</p> <p>R94 was observed in bed on his/her back, and</p> | F 656 | <p>Step 4: To monitor and maintain ongoing compliance the DON and/or designee will review 10 residents weekly for 4 weeks and then 10 residents monthly for 2 months for behavioral care plans related to (noncompliance, noncompliance with care, verbal aggression), tracheostomies, and artificial airway complications; as indicated until 100 percent compliance is reached times 2 months. Results will then be reported to QAPI committee for further review and recommendations.</p> | | |

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| F 656 | <p>Continued From page 8</p> <p>heels were not offloaded: 7/22/19 12:37 PM, 7/22/19 1:40 PM, 7/23/19 9:23 AM, 07/23/19 12:14 PM</p> <p>7/23/19 2:11 PM - In an interview with E1 (NHA) it was confirmed that the only care planned documentation was refusal of medications, and R94's care plan did not reflect his/her refusal for skin prevention interventions, such as turning and repositioning or offloading heels.</p> <p>The the facility failed to care plan for R94's physician's order to off load heels. R94's care plan did not address R94's refusals of turning and positioning, and offloading of his/her heels.</p> <p>7/23/19 4:30PM- Findings were reviewed during the exit conference with E1 (NHA), E2 (DON), and E4 (RDSCS) Cross refer F695, example 1b.</p> <p>3. Review of R102's clinical record revealed the following:</p> <p>3/28/19 - R102 was admitted to the facility from the hospital with tracheostomy due to respiratory failure.</p> <p>4/8/19 (Revision date of 7/4/19) - A care plan titled tracheostomy had a goal that patency of R102's airway will be maintained for the next 90 days. Interventions included:</p> <ul style="list-style-type: none"> - Currently capping trial (6/25/19). - Administer oxygen per physician order. - Assess respiration: not the quality, rate, rhythm, nasal flaring, use of accessory muscle. - Consult respiratory therapist. - Encourage resident to cough out secretions. - Pass Muir valve per orders. - Suction as needed. | F 656 | | | |

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| F 656 | <p>Continued From page 9</p> <p>- Trachostomy care per protocol.</p> <p>7/10/19 - Physician orders which included "... emergency traches in bag #4 Shiley...weaned and capping 24/7 on 2 L/M."</p> <p>The facility failed to develop and implement a comprehensive person-centered care plan for R102 who had a tracheostomy. The care plan for tracheostomy failed to include the type and size of the airway, the specific risks for complications including mucous plug and obstructed airway.</p> <p>7/23/19 4:30PM- Findings were reviewed during the exit conference with E1 (NHA), E2 (DON), and E4 (RDCCS).</p> <p>4. 3/13/19- R69 was admitted to the facility.</p> <p>3/21/19- A care plan was initiated stating that R69 had the potential to demonstrate verbally abusive behaviors. Interventions included for staff to document observed behaviors and attempted interventions in R69's behavior log.</p> <p>4/11/19- A care plan was initiated stating that R69 was non-compliant related to keeping his/her bed in a high position, refusing personal care, brief changes, turning and repositioning, out of bed to chair and use of call bell for safety. Interventions included charting R69's behaviors every shift.</p> <p>4/11/19-4/30/19- Review of R69's documentation survey report revealed that for 40 out of 60 shifts, staff were not documenting if R69 did or did not have any behaviors.</p> <p>5/1/19-5/31/19- Review of R69's documentation</p> | F 656 | | | |

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| F 656 | Continued From page 10 survey report revealed that for 72 out of 93 shifts, staff were not documenting if R69 did or did not have any behaviors. 6/1/19-6/30/19- Review of R69's documentation survey report revealed that for 83 out of 90 shifts, staff were not documenting if R69 did or did not have any behaviors. 7/1/19-7/22/19- Review of R69's documentation survey report revealed that for 58 out of 66 shifts, staff were not documenting if R69 did or did not have any behaviors. 7/23/19 2:03 PM- During an interview, E2 (DON) confirmed that staff were not consistently documenting R69's behaviors every shift. The facility failed to implement R69's care plan intervention to chart his/her behaviors every shift. 7/23/19 4:30PM- Findings were reviewed during the exit conference with E1 (NHA), E2 (DON), and E4 (RDCS). | F 656 | | | |
| F 657 SS=D | Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the | F 657 | | 8/22/19 | |

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| F 657 | <p>Continued From page 11</p> <p>resident.</p> <p>(D) A member of food and nutrition services staff.</p> <p>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.</p> <p>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.</p> <p>(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, it was determined that the facility failed to revise the care plan to reflect current resident's needs for two (R59, R105 out of 28 sampled residents. Findings include:</p> <p>Review of R59's clinical record revealed the following:</p> <p>12/23/14 - R59 was readmitted to the facility with diagnoses that included dementia and muscle weakness.</p> <p>10/29/18 - A comprehensive MDS assessment documented no signs and symptoms of a possible swallowing disorder while on a therapeutic diet (for example: low salt, diabetic, low cholesterol).</p> <p>The succeeding quarterly MDS assessments on 12/18/18 and 3/5/19 documented no signs and</p> | F 657 | <p>F657D - Care Plan Timing and Revision</p> <p>Step 1: R59 s care plan was updated to reflect impaired swallowing and aspiration interventions related to dysphagia. Fees was removed from care plan. R105 s care plan was updated to reflect the functional use of their G and J tubes.</p> <p>Step 2: Residents with dysphagia have the potential to be affected. The DON and/or designee audited care plans for residents with dysphagia to ensure they reflect risk for impaired swallowing and aspiration. Where necessary the care plan was updated. Residents with enteral tubes have the potential to be affected. The DON and/or designee reviewed current residents with G or J tubes to ensure care</p> | | |

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| F 657 | <p>Continued From page 12</p> <p>symptoms of a possible swallowing disorder while on a therapeutic diet.</p> <p>5/30/19 - A speech therapy (ST) assessment summary indicated that ST needed a swallowing study in order to determine R59's true swallowing function.</p> <p>6/3/19 - A care plan (difficulty swallowing) was developed for the problem of being at risk for impaired swallowing/aspiration (inhaling fluid or food into the lungs) related to dysphagia (a disorder in swallowing or difficulty swallowing) with interventions to include FEES (fiberoptic endoscopic evaluation of swallowing) ordered due to suspected aspiration.</p> <p>6/5/19 - A quarterly MDS assessment documented no signs and symptoms of a possible swallowing disorder while on a mechanically altered diet (R59 required a change in texture of food and liquids to pureed food and thickened liquids).</p> <p>6/6/19 - A ST discharge summary indicated that R26 was discharged from speech therapy services due to refusal of treatment.</p> <p>6/6/19 at 11:00 AM - A physician's order was noted to discontinue ST services and to discontinue FEES due to R59 declining ST services.</p> <p>7/22/19 at 2:00 PM - Review of R59's care plan for dysphagia revealed that the swallowing evaluation (FEES) order remained an active intervention, although it was discontinued by the physician on 6/6/19.</p> | F 657 | <p>plans reflect their ordered use. Where necessary the care plan was updated.</p> <p>Step 3: To prevent this from recurring the DON and/or designee will educate licensed nursing staff on the review and revision of resident care plans when a physical or cognitive change occurs.</p> <p>Step 4: To monitor and maintain ongoing compliance the DON and/or designee will audit care plans of 5 residents with dysphagia to ensure they reflect risk for impaired swallowing and aspiration and 5 residents with G or J tubes to ensure care plans reflect their ordered use, weekly for 2 months until 100 percent compliance. Results will then be reported to QAPI committee for further review and recommendations.</p> | | |

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| F 657 | <p>Continued From page 13</p> <p>The facility failed to review and revise R59's care plan to reflect updated and revised interventions to help manage R26's risk for impaired swallowing and aspiration related to dysphagia.</p> <p>Findings were reviewed with E1 (NHA), E2 (DON), and E4 (Regional Director of Clinical Services) during the Exit Conference on 7/23/19 beginning at approximately 4:30 PM.</p> <p>2. Review of R105's clinical record revealed:</p> <p>6/6/19 - R105 was re-admitted to the facility from the hospital with diagnoses that included dysphagia, end stage kidney disease, and anoxic brain damage. R105 was admitted with a jejunostomy tube (J-tube) and a gastrostomy tube (G-tube).</p> <p>6/6/19 - Physician orders stated that medication was to be given "via tube". The order did not specify which tube medication was to be given through.</p> <p>6/17/19 - R105 was sent to the hospital for a clogged J-tube, requiring a J-tube replacement.</p> <p>6/19/19 - Physician orders stated that medication was to be given via the G-tube.</p> <p>6/28/19 - R105 was sent to the hospital for a clogged J-tube, requiring a J-tube replacement.</p> <p>7/2/19 - R105 had a care plan for a feeding tube. There was nothing specific in R105's care plan interventions regarding his/her J-tube and G-tube, including what tube was to be used for feeding and what tube was to be used for medication, despite a physician's order to give medications</p> | F 657 | | | |

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| F 657 | Continued From page 14 via the G-tube. 7/7/19 at 8:44 PM - A nurses progress note written by E67 (LPN) stated that the J-tube was noted to be clogged and E67 was unable to start the tube feeding. E67 attempted to unclog the tube but was not successful. An order was obtained to send R105 to the hospital for a clogged J-tube. The facility failed to update R105's care plan to clarify what could be administered via G-tube and what could be administered via J-tube. Findings were reviewed with E1 (NHA), E2 (DON), and E4 (RDSCS) on 7/23/19 at 4:30 PM during the exit conference. | F 657 | | | |
| F 677 SS=D | ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, record review and interview, it was determined that the facility failed to provide the necessary services to maintain good nail grooming for one (R99) resident who was unable to carry out activities of daily living, out of 5 residents sampled for ADL care. Findings include: Review of R99's clinical record revealed: R99 was admitted to the facility on 6/5/19. R99's admission MDS, dated 6/12/19, stated that R99 | F 677 | F677D - ADL Care Provided for Dependent Residents Step 1: R99 had fingernails cut on 7/17/19. Step 2: Dependent residents have the potential to be affect. The DON and/or designee observed all resident fingernails to ensure they were trim. Where necessary, finger nails were cut. | 8/22/19 | |

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| F 677 | Continued From page 15 required extensive assistance with personal hygiene, which included nail trimming. R99 had a care plan, initiated on 6/16/19, for the problem that R99 had a self care deficit. Approaches included that R99 required assistance with activities of daily living, including grooming. On 7/11/19 at 1:22 PM, it was observed that R99's fingernails were long. On 7/16/19 at 10:10 AM, it was observed that R99's fingernails were long and dirty. On 7/16/19 at 10:14 AM, during an interview, E7 (RN) stated that the CNA's and the nurses check resident's fingernails. E7 stated if the fingernails are too long, a nurse would trim the resident's nails. E7 confirmed that R99's fingernails were too long and stated that he/she would make sure they were trimmed. On 7/17/19 at 11:05 AM, it was observed that R99's fingernails were trimmed and clean. The facility failed to ensure nail care was provided for a resident who was dependent on the facility for personal hygiene. Findings were reviewed with E1 (NHA), E2 (DON) and E4 (RDCS) during the exit conference on 7/23/19 at approximately 4:30 PM. | F 677 | Step 3: To prevent the potential for reoccurrence the DON and/or designee will educate nursing staff on dependent resident ADL care with emphasis on ensuring fingernails are clean and trimmed. Step 4: To monitor and maintain ongoing compliance the DON and/or designee will observe 10 resident fingernails 1 time weekly for 3 months, until 100 percent compliant. Results will then be reported to QAPI committee for further review and recommendations. | |
| F 684 SS=D | Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that | F 684 | | 8/22/19 |

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| F 684 | <p>Continued From page 16</p> <p>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:</p> <p>Based on clinical record reviews and interviews, it was determined that for one (R81) out of 13 sampled residents for investigation, the facility failed to ensure that each resident received treatment and care in accordance with comprehensive person-centered care plan. For R81, the facility failed to follow his/her physician's order for Accucheck to be performed at bedtime. Findings include:</p> <p>Review of R81's clinical record revealed the following:</p> <p>6/5/19 - A physician's order stated to perform Accuchecks before each meal and at bedtime.</p> <p>6/5/19 through 6/30/19 - The Medication Administration Record lacked evidence that the order to perform Accucheck at bedtime was transcribed, thus, not performed.</p> <p>7/17/19 3:56 PM - An interview with E31 (RN) revealed that a bedtime Accucheck would have been scheduled for 8:00 PM. E31 verbalized that he/she was not able to locate whether the Accucheck was performed from 6/5/19 through 6/30/19.</p> <p>7/18/19 9:44 AM - An interview with E2 (DON) confirmed that the facility failed to transcribe the</p> | F 684 | <p>F684D - Quality of Care</p> <p>Step 1: R81 was assessed with no negative findings. Medication error report completed. Physician and family were notified.</p> <p>Step 2: Residents requiring blood glucose testing via finger stick have the potential to be affected. The DON and/or designee reviewed all diabetic resident orders to ensure blood glucose testing parameters were transcribed correctly to the MAR. If indicated, a resident assessment will be completed, a medication error report generated, and the affected residents physician/family made aware.</p> <p>Step 3: To prevent the potential for reoccurrence the DON and/or designee will educate license nurses on proper transcription of physician orders with emphasis on blood glucose testing via finger stick.</p> <p>Step 4: To monitor and maintain ongoing compliance the DON and/or designee will review all new blood glucose monitoring</p> | | |

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| F 684 | Continued From page 17 order for bedtime Accucheck on the June 2019 MAR, thus, Accucheck was not performed at bedtime from 6/5/19 through 6/30/19, as ordered. | F 684 | orders 5 times weekly for 3 months until 100 percent compliant. Results will then be reported to QAPI committee for further review and recommendations | | |
| F 688 SS=D | Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, it was determined that the facility failed to ensure that a resident with limited range of motion (ROM) received appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion for one (R37) out of one residents investigated for position/mobility. Findings include: | F 688 | F688D - Increase /Prevent Decrease in ROM/Mobility Step 1: R37 was screened by therapy to ensure contracture management was maintained and to confirm the appropriateness of a left sided palm guard. A physicians order | 8/22/19 | |

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| F 688 | <p>Continued From page 18</p> <p>Review of R37's clinical record revealed:</p> <p>A. 7/15/15- R37 was admitted to the facility with diagnoses including CVA and spastic hemiplegia affecting the left side.</p> <p>10/23/18- A physicians order was entered for R37 to have a left palm guard applied after morning care and removed at bedtime.</p> <p>2/13/19 - A care plan was developed stating that R37 had a self-care deficit. Interventions included for R37 to have his/her left hand palm guard on in the morning and off at night per orders.</p> <p>7/11/19 10:24 AM- R37 was observed lying in bed watching television. R37 did not have the left palm guard in place.</p> <p>7/11/19 2:06 PM- R37 was observed sitting up in a chair watching television. R37 did not have the left palm guard in place.</p> <p>7/16/19 11:37 AM- R37 was observed lying in bed and resting. R37 did not have the left palm guard in place.</p> <p>7/17/19 12:00 PM- R37 was observed lying in bed watching television. R37 did not have the left palm guard in place. R37 confirmed that he/she already had morning care provided that day. The surveyor asked R37 if staff usually apply his/her left palm guard. R37 stated no and stated that he/she wanted to wear it. The surveyor confirmed with E26 (LPN) that R37's left palm guard was not in place. E26 got R37's palm guard from his/her nightstand and placed it on R37's left palm.</p> | F 688 | <p>was obtained to decrease passive range of motion to once a day. R37 s plan of care updated.</p> <p>Step 2: Residents utilizing palm guards have the potential to be affected. The DON and/or designee observed residents with palm guard(s) to ensure they were being utilized as ordered. Where necessary palm guard use was corrected. Residents with passive range of motion (PROM) programs have the potential to be affected. The DON and/or designee audited all PROM orders to ensure they were correctly transcribed to the restorative record. Where indicated the resident PROM order was verified with the physician and corrected.</p> <p>Step 3: To prevent the potential for reoccurrence the DON and/or designee will educate nursing staff on contracture management with emphasis on following PROM and palm guard application orders. Nursing staff will also receive education on reporting poor program tolerance to the licensed nurse, should it occur.</p> <p>Step 4: To monitor and maintain ongoing compliance the DON and/or designee will review 5 residents utilizing a palm guard along with 5 residents on PROM programs to validate procedural compliance weekly for 4 weeks and then</p> | | |

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| F 688 | <p>Continued From page 19</p> <p>7/2019- Review of R37's July ETAR revealed that from 7/1/19 to 7/17/19 staff were not signing off applying R37's left palm guard. Staff documented removing R37's left palm guard at 8:30 PM on all days except 7/14/19 and 7/16/19.</p> <p>The facility failed to ensure that R37's left palm guard was applied per physicians orders to prevent a further decline in his/her range of motion.</p> <p>7/23/19 4:30PM- Findings were reviewed during the exit conference with E1 (NHA), E2 (DON), and E4 (RDCS).</p> <p>B. 10/23/18- A physicians order was entered for R37 to participate in restorative PROM (Passive Range of Motion) twice daily for 15 minutes each session.</p> <p>6/1/19-7/18/19- Review of R37's restorative program PROM documentation revealed that from 6/1/19 to 6/20/19 staff documented that R37 received PROM two times a day for 15 minutes each session. There were no documented refusals. On 6/21/19, the document stated that R37 was changed to PROM one time a day five days a week. From 6/21/19 to 7/18/19, staff documented R37 receiving PROM once daily for 15 minutes five days a week; however, R37's physician order still stated he/she was to receive PROM twice daily.</p> <p>7/18/19 10:22 AM- During an interview, E64 (LPN) stated that R37 was not tolerating his/her twice a day PROM. E64 stated that from talking to the restorative aids and R37, it was decided that R37's PROM was going to be changed to once a day. E64 stated she did not realize that</p> | F 688 | monthly for 2 months until 100 percent compliant. Results will then be reported to QAPI committee for further review and recommendations. | |
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| F 688 | Continued From page 20 R37's physician order specified that he/she was to have PROM twice daily, and that it would be changed. The facility failed to ensure that R37 received PROM twice daily per physician orders to prevent a further decline in his/her range of motion from 6/21/19 to 7/18/19. 7/23/19 4:30PM- Findings were reviewed during the exit conference with E1 (NHA), E2 (DON), and E4 (RDCS). | F 688 | | | |
| 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 observation, record review, and interview, it was determined that for three (R16, R84, and R92) out of 45 sampled residents observed during random observations, the facility failed to ensure that the resident's environment remained as free of accident hazards as much as possible. Findings include: 1. Review of R16's clinical record revealed: 7/16/17- R16 was admitted to the facility with diagnoses that included quadriplegia and a personal history of self-harm. | F 689 | F689D - Free of Accidents Hazards/Supervision/Devices Step 1: R16, 84, and 92 s beds were placed in the lowest position. Step 2: Residents requiring a low bed have the potential to be affected. The DON and/or designee observed all residents with low bed orders to ensure compliance. Where necessary, the resident s bed was | 8/22/19 | |

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| F 689 | <p>Continued From page 21</p> <p>1/29/19- A care plan was initiated stating that R16 was at risk for falls. Interventions included for R16's bed to be in a low position.</p> <p>7/8/19- R16's quarterly MDS stated that R16 was cognitively intact and was totally dependent for bed mobility and transfers.</p> <p>7/12/19 9:37AM- R16 was observed lying in bed with his/her bed elevated off the ground in a high position. No staff were in the room. R16 stated that his/her bed should be lower than this, and stated that their bed had been raised up like that since breakfast. After completing the interview with R16, the surveyor notified E26 (LPN) at 10:10 AM. E26 continued to complete other work and went to lower R16's bed at approximately 10:13 AM.</p> <p>7/16/19 10:45 AM- R16 was again observed lying in bed with his/her bed elevated off the ground in a high position. No staff were in the room. R16 stated that his/her bed had been that high for approximately 45 minutes. The surveyor notified E26 (LPN) about R16's elevated bed at 10:48 AM. E26 continued to complete other work and went into R16's room to lower the bed at 10:53 AM.</p> <p>The facility failed to ensure that R16's environment remained free of accident hazards, as evidenced by two different observations of R16 alone in his/her room with the bed at an elevated height.</p> <p>7/23/19 4:30PM- Findings were reviewed during the exit conference with E1 (NHA), E2 (DON), and E4 (RDCS).</p> | F 689 | <p>lowered.</p> <p>Step 3: To prevent the potential for reoccurrence the DON and/or designee will educate all nursing staff resident safety with emphasis on maintaining low beds, when ordered</p> <p>Step 4: To monitor and maintain ongoing compliance the DON and/or designee will review 1 resident hallway daily on day, evening, and night shifts for 2 weeks to ensure beds are in the lowest position; where ordered, then 1 time weekly for 2 months until 100 percent compliant. Results will then be reported to QAPI committee for further review and recommendations.</p> | | |

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| F 689 | <p>Continued From page 22</p> <p>2. Review of R92's clinical record revealed:</p> <p>6/17/16- R92 was admitted to the facility with diagnoses that included seizures and anoxic brain damage.</p> <p>3/28/19- A care plan was initiated stating that R92 was at risk for falls. Interventions included for R92's bed to be kept in a low position.</p> <p>6/12/19- R92's significant change MDS stated that R92 was in a vegetative state and was totally dependent for bed mobility and transfers.</p> <p>7/16/19 11:45 AM- R92 was observed lying in bed with his/her bed elevated off the ground in a high position. No staff were in the room. The surveyor notified E2 (DON) of R92's bed height. E2 confirmed the finding and lowered R92's bed.</p> <p>The facility failed to ensure that R92's environment remained free of accident hazards, as evidenced by an observation of R92 alone in his/her room with the bed at an elevated height.</p> <p>7/23/19 4:30PM- Findings were reviewed during the exit conference with E1 (NHA), E2 (DON), and E4 (RDGS).</p> <p>3. Review of R84's clinical record revealed:</p> <p>6/12/19- R84 was admitted to the facility with diagnoses that included left sided weakness following a stroke, a seizure disorder, and dementia.</p> <p>6/19/19- R84's admission MDS stated that R84 was moderately cognitively impaired and required extensive assistance for bed mobility and</p> | F 689 | | | |

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| F 689 | Continued From page 23 transfers. 6/25/19- A care plan was initiated stating that R84 was at risk for falls. Interventions included for R84's bed to be kept in a low position. 7/11/19 at 10:45 AM - R84 was observed dozing in her bed with the bed in a high position. R84 was alone in his/her room. 7/11/19 at 10:46 AM - E8 (RN) stated that R84 had the Hoyer lift sling under him/her and the aide should not have left him/her like that. E8 lowered the bed. The facility failed to ensure that R84's environment remained as free of accident hazards as possible, as evidenced by an observation of R84 alone in his/her room with the bed at an elevated height. 7/23/19 4:30 PM- Findings were reviewed during the exit conference with E1 (NHA), E2 (DON), and E4 (RDSCS). | F 689 | | | |
| F 692 SS=D | Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte | F 692 | | 8/22/19 | |

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| F 692 | <p>Continued From page 24</p> <p>balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;</p> <p>§483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;</p> <p>§483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview, record review, and review of facility policy, it was determined that the facility failed to recognize, evaluate, and address a significant weight changes for three (R35, R40, and R92) out of four sampled residents. Findings include:</p> <p>The facility's policy titled, "Weight Policy ", effective 5/2015, revised 6/2016, indicated, "Reweights: 1. For residents who weigh > 100# (greater than 100 pounds), all weight changes showing a gain or loss of 5 lbs (pounds) or more from the previous weight require a reweigh within 24 hours ...3. All significant weight changes must be communicated to the resident if appropriate, the attending physician and responsible party."</p> <p>1. Review of R40's clinical record revealed:</p> <p>7/26/06 - R40 was admitted to the facility.</p> <p>11/14/18- A care plan was initiated stating that R40 had a swallowing disorder related to dysphagia. Interventions included monitoring R40's weight per routine and protocol.</p> <p>5/10/19- A care plan was initiated stating that R40</p> | F 692 | <p>F692D - Nutrition/Hydration Status Maintenance</p> <p>Step 1: Residents 35, 40 and 92 weights were evaluated and addressed secondary to a significant weight change. New orders received from physician and/or Registered Dietitian (RD) where indicated. Responsible parties notified</p> <p>Step 2: Residents demonstrating a significant weight change have the potential to be affected. The RD and/or designee reviewed with significant weight changes to ensure an evaluation and reaction had occurred. Where necessary new orders were be received and carried out. The affected resident s responsible party was also notified.</p> <p>Step 3: To prevent the potential for reoccurrence the NHA and/or designee will educate RD on weight loss policy and licensed nursing staff on significant weight changes with</p> | | |

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| F 692 | <p>Continued From page 25</p> <p>was at increased nutritional risk related to gastric tube use related to dysphagia. Interventions included monitoring R40's weight per protocol and monitoring R40's need for increased nutritional interventions.</p> <p>6/22/19- 7/2/19- Review of R40's weights revealed that on 6/22/19 R40 was 104.94 lbs. On 7/1/19, R40 was 118.0 lbs, which was a 12.45% significant weight change. R40 was reweighed on 7/2/19 and was 117.3 lbs.</p> <p>7/2/19 1:06 PM- A progress note by E65 (Dietician) documented a medical nutrition therapy assessment, however, the current weight that E65 referred to in the assessment was R40's weight on 6/22/19 of 104.94 lbs. E65 never mentioned R40's significant weight gain of 12.45%. The assessment evaluation stated that she recommended increasing R40's tube feeding regimen, however, she was basing this off of R40's weight of 104.94 lbs not his/her current weight of 117.3 lbs.</p> <p>7/23/19- Review of R40's clinical record showed no evidence that E65 (Dietician) was aware of R40's significant weight change on 7/1/19, and no evidence that an assessment of this weight change was completed. In addition, there was no evidence that the physician or R40's representative were notified of this significant weight change per facility policy.</p> <p>The facility failed to recognize, evaluate, and address R40's significant weight change, and failed to notify the physician and resident's representative per facility policy.</p> <p>7/23/19 4:30 PM- Findings were reviewed during</p> | F 692 | <p>emphasis on reporting these changes to the dietitian and physician.</p> <p>Step 4: To monitor and maintain ongoing compliance the NHA and/or designee will review 5 residents with significant weight changes weekly for 3 months to ensure an evaluation and response are evident along with physician/responsible party notification until 100 percent compliant. Results will then be reported to QAPI committee for further review and recommendations.</p> | | |

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| F 692 | <p>Continued From page 26 the exit conference with E1 (NHA), E2 (DON), and E4 (RDCS).</p> <p>2. Review of R92's clinical record revealed:</p> <p>6/17/16- R92 was admitted to the facility.</p> <p>4/1/19- 4/9/19- Review of R92's weights revealed that he/she weighed 187.7 lbs on 4/1/19 and increased to 190.1 lbs on 4/9/19.</p> <p>5/3/19- A care plan was initiated stating that R92 was at increased nutritional risk related to gastric tube related to dysphagia. The goal initiated on 6/10/19 was for R92 to lose 6-12 lbs through the next review. Interventions included monitoring R92's weight per protocol and monitoring R40's need for increased nutritional intervention.</p> <p>6/8/19- 6/18/19- Review of R92's weights revealed that he/she had an increase in weight from 220 lbs on 6/8/19 to 236.8 lbs on 6/12/19. This was a significant weight gain of 7.64% and was greater than a 5 lb increase. There was no documented reweight within 24 hours and no evidence that the physician or resident's representative were notified per the facilities policy. In addition, there was no evidence that the dietician assessed R92's significant weight increase at this time. R92 did not have a reweight until 6/18/19 that was 233.6 lbs.</p> <p>6/24/19 8:27 AM- A progress note by E65 (Dietician) was the first documentation acknowledging R92's significant weight change. E65 stated that the resident was noted with weight variations during the month of June and had a weight gain of "16.8#" noted from 6/8/19 to 6/12/19. Weight loss of 3.2# noted from 6/12/19</p> | F 692 | | | |

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| F 692 | <p>Continued From page 27</p> <p>to 6/18/19. Another weight was taken on 6/18/19 that showed a 27.2# weight loss from the previous weight from earlier that day...No recent changes to tube feeding regimen. Will continue to monitor resident's weight." There was again no evidence that R92's physician and resident representative were notified of this weight change.</p> <p>7/1/19- 7/19/19- Review of R92's weights revealed that on 7/1/19 R92's weight was 227.7 lbs and decreased to 195.6 lbs on 7/10/19. This was a weight decrease of 14.10%. There was no evidence that E65 (Dietician) was aware of this weight decline and had assessed R92. There was no evidence that the physician or R92's representative were notified of this significant weight change per facility policy. In addition, a reweight was not completed 24 hours later per facility policy. The next weight documented for R92 was not until 7/19/19 and was 195.8 lbs.</p> <p>7/22/19 10:15 AM- During an interview, E65 (Dietician) stated that she reviewed weights on a weekly basis, but did not see R92's weight on 7/10/19. E65 stated that the system notified her of significant weight changes. E65 stated that she was not sure what the facility policy stated for weight loss, but she thought that she was supposed to notify the physician of any significant weight changes. E65 stated that she had not been notifying the physician of all significant weight changes.</p> <p>The facility failed to recognize, evaluate, and address R92's significant weight changes, and failed to reweigh within 24 hours and notify the physician and resident's representative per facility policy.</p> | F 692 | | | |

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| F 692 | Continued From page 28 7/23/19 4:30 PM- Findings were reviewed during the exit conference with E1 (NHA), E2 (DON), and E4 (RDCS). 3. Review of R35's clinical record revealed the following: On 7/29/16, R35 was admitted to the facility with diagnoses that included Alzheimer's dementia. On 5/7/19, an annual nutrition assessment revealed that R35 ate a regular diet, and weighed 171.2 pounds. R35 was able to feed his/her self with set up help only. It was noted that R35 was at potential for nutritional risk due to the need for a therapeutic diet. The nutritional plan was to consider adjustment of the care plan based on the next obtained weight, and continued monitoring of weight and meal intake. On 5/20/19 at 6:09 PM, a nutritional progress note written by E65 (Dietician) stated that the 5/6/19 annual MDS was modified to show a significant weight change. R35 was noted with weight variations recently, and R35 experienced a significant weight loss of 6.70% from 4/2/19 to 5/2/19. On 5/22/19, a physician's progress note written by an NP stated that weight gain or loss was absent. On 6/26/19, a physician's progress note written by an NP stated that weight gain or loss was absent. R35's documented weights (in pounds) were as follows: 1/5/19 191.0; 2/13/19 183.4 ; | F 692 | | | |

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| F 692 | <p>Continued From page 29</p> <p>3/10/19 177.2 (standing); 3/22/19 175.2; 4/2/19 183.5; 5/2/19 171.2; 5/13/19 166.2; 5/15/19 171 (standing); 6/12/19 168.6 - 11.36% weight loss in 6 months; 7/2/19 157.8 - 6.41% weight loss in 1 month.</p> <p>Review of R35's physician orders revealed no physician orders for nutritional supplements.</p> <p>On 7/12/19 at 1:11 PM, R35 was observed at lunch in the main dining room. R35 did not eat any of his/her lunch. R35 left the dining room without eating any of his/her lunch, yet the documentation survey report for R35's lunch intake was documented as 51-75% of the meal eaten.</p> <p>On 7/18/19 at 3:34 PM, during an interview E66 (Corporate Dietitian) stated he/she would have expected to see supplements added to R35's diet with the documented weight loss.</p> <p>On 7/22/19 at 10:14 AM, during an interview E65 (Dietician) stated the nutritional interventions for R35 were to review weights weekly, to review meal intake, and to assess for any contributing factors such as edema. E65 stated that R35's weight loss from 183.5 pounds on 4/2/19 to 157.8 pounds on 7/2/19 (a 14.1% weight loss in 3 months) was flagged in the electronic medical record and he/she should have reviewed the medical record for interventions. E65 stated that he/she was unsure what the facility policy was regarding resident weight loss.</p> <p>The facility failed to recognize, evaluate, and</p> | F 692 | | | |

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| F 692 | Continued From page 30 address the nutritional needs of R35, or to develop and implement interventions to stabilize and/or improve R35's nutritional status. | F 692 | | | |
| F 693 SS=E | Findings were reviewed with E1 and E2 on 7/23/19 at 4:30 at exit conference Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on review of facility policy and procedures, it was determined that the facility failed to ensure their procedure for checking correct placement was in accordance to current standards of practices. and review of clinical | F 693 | F693E - Tube Feeding Mgmt/Restore Eating Skills Step 1: Enteral tube placement check | 8/22/19 | |

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| F 693 | <p>Continued From page 31 records. Findings include:</p> <p>Review of the facility's policy and procedure and the following clinical references revealed:</p> <p>The facility policy and procedure (P & P) for Gastrostomy Tube (GT)/Jejunostomy Tube (JT) Care, with a revision date of October 2019, indicated that the licensed nurse will provide routine care to gastrostomy and jejunostomy tubes in order to maintain patency of the tube. "Procedure:...8. To confirm placement of tube in stomach: a. Attach syringe to end of tube and place stethoscope over left quadrant of resident's abdomen. Instill 20 cc of air into the tube and listen for swooshing sound in stomach. b. Aspirate stomach contents by attaching syringe to end of tube and gently pulling back on plunger."</p> <p>Review of the following current standards of practice for tube placement verification revealed that auscultation was no longer recommended:</p> <ul style="list-style-type: none"> - "Auscultation (listening) is no longer recommended for checking placement of the feeding tube. Movement of air would likely be heard whether the tube was in the correct or incorrect location." (https://www.ismp.org/tools/articles/ASPEN.pdf). - "Auscultation verification of gastric tube (feeding tube) placement solely by auscultation (listening), which involves instillation of air into the tube while simultaneously listening with a stethoscope over the epigastric (abdominal) region for the sound of air, is no longer recommended." (Emergency Nurses Association, Clinical Practice Guidelines: Gastric Tube Placement Verification, 2017). | F 693 | <p>competency was updated to reflect current Centers for Medicare and Medicaid (CMS) recommendations.</p> <p>Step 2: Facility enteral feeding policies were reviewed to ensure current recommendations are reflected. Where necessary, policy was updated to reflect current standards. Auscultation was removed as a method of checking for tube placement.</p> <p>Step 3: To prevent the potential for reoccurrence the DON and/or designee will competency all licensed nursing staff on the updated enteral placement procedure.</p> <p>Step 4: To monitor and maintain ongoing compliance the DN/Designee will conduct 2 residents audit weekly to ensure tube placement check is done correctly times 2 months until 100 percent compliant and licensed staff will competency annually. Results will be reported to QAPI committee for further review and recommendations.</p> | |
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| F 693 | Continued From page 32 - " Nurses should not use the auscultatory (air bolus) ..." (American Association of Critical-Care Nurses updates Practice Alert on feeding tube placement 4/1/16). 7/22/19 From 3:20 PM to 3:40 PM - Interviews with multiple licensed nurses, from both day and evening shift revealed, to ensure proper placement of a feeding tube, GT or JT, that they would instill air via syringe, place stethoscope over resident's abdomen and listen for swooshing sound in stomach as well as aspirate stomach contents by attaching syringe to end of tube and gently pulling back on plunger. These staff included E5 (RN), E7 (RN), E8 (RN), E9 (RN), E10 (RN), and E11 (RN), 7/23/19 10:00 AM - An interview with E1 (NHA) revealed that since the above standards of practice was only a recommendation not to auscultate, the facility will continue with the current procedure, as documented in the above P & P, however, E1 verbalized that he/she has elevated this within their organization. The facility failed to ensure their procedure for checking correct placement was in accordance to current standards of practices. Findings were reviewed with E1 (NHA) and E2 (DON) during the Exit Conference on 7/23/19 beginning at approximately 4:00 PM. | F 693 | | | |
| F 695 SS=J | Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. | F 695 | | 7/24/19 | |

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| F 695 | <p>Continued From page 33</p> <p>The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, clinical record review, and review of the facility's policy and procedure, it was determined that the facility failed to ensure emergency equipment and competent staff were available for accidental tracheostomy (trach) tube decannulation for two (R51 and R102) out of three active residents in the sample with tracheostomies. The lack of available emergency equipment, in addition to the lack of competent trained staff in emergency trach tube replacement, placed R51 and R102 at a high likelihood of serious harm. The Immediate Jeopardy (IJ) was identified on 7/16/19 at 1:35 PM and abated on 7/16/19 at 6:32 PM. Findings include:</p> <p>The facility policy and procedure entitled Emergency Tracheostomy Replacement Policy (Effective June 19, 2017) included:</p> <ul style="list-style-type: none"> -Initial placement of the tracheostomy tube and first tube change should be done by the physician. Replacement in an emergency situation may be performed by a respiratory care practitioner or nurse. -A second tracheostomy tube of the same style and size, and one smaller size if applicable, should always be boxed at the patient's bedside and the obturator for the existing tube is at the bedside as well. This extra tube can be used if there is a malfunction with the airway device. | F 695 | <p>F695J - Respiratory/Tracheostomy Care and Suctioning</p> <p>Step 1: R51 has a physician order to send to the hospital if his tracheostomy dislodges and to not reinsert. R102 is discharged. Competent staff is available in the event of unplanned decannulation.</p> <p>Step 2: Residents with a tracheostomy have the potential to be affected. The DON and/or designee observed residents with tracheostomies to ensure a trach of the ordered size, and one the next size down, were available at bedside. If necessary, the bedside tracheostomy was obtained and placed. Trach supplies monitored every two weeks, new supplies ordered when indicated. Licensed nursing staff have received education and competencies on accidental decannulation.</p> <p>Step 3: To prevent the potential for reoccurrence the DON and/or designee will educate nursing staff on bedside supplies for</p> | | |

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| F 695 | <p>Continued From page 34</p> <p>1. The following was reviewed in R51's clinical record:</p> <p>12/6/18 - R51 was admitted to the facility with a diagnosis of traumatic brain injury and a tracheostomy. R51 was a full code which signifies that R51 was to receive CPR in the event of cardiac/respiratory arrest.</p> <p>Review of the physician order sheets (POS) for April, May, June and July, 2019 lacked a physician's order for R51's tracheostomy size.</p> <p>4/23/19 - R51's physician's order included: Tracheostomy was down-sized from 6 XLT to size 4. Check Pulse Ox every 4 hours status post trach down size.</p> <p>4/25/19 12:52 PM - A Physician Progress Note documented..."[R51] seen for tracheostomy replacement due to hypoxia...[his/her] trach downsized to a #4 but later desaturated and was taken to the ER. There the trach was replaced with a #6 and oxygen saturation improved. [He/she] is now at 96%." .</p> <p>5/28/19 - A quarterly MDS documented that R51 was cognitively intact and required extensive assist of staff for activities of daily living.</p> <p>7/16/19 11:42 AM - In an interview and observation with E8 (RN), R51 was able to make needs known by forming unheard words, and the surveyor and staff were able to read R51's lips. R51 stated that Respiratory Therapy was coming that day to put in a smaller trach tube.</p> <p>7/16/19 12:05 PM - During an observation, E5</p> | F 695 | <p>tracheostomy residents with emphasis on a backup tracheostomy of current and smaller size.</p> <p>Step 4: To monitor and maintain ongoing compliance the DN/Designee will review tracheostomy residents for the presence of bedside supplies 1 time weekly for 3 months until 100 percent compliant. Review of staffing will be done weekly for 3 months to ensure at least 1 licensed trained staff member is available on each shift in the event of accidental decannulation. Results will then be reported to QAPI committee for further review and recommendations.</p> | | |

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| F 695 | <p>Continued From page 35</p> <p>(RN, UM) looked in R51's personal treatment cart in the room, looked on R51's bedside table and was not able to locate a replacement trach. After approximately five minutes, E5 was able to locate a replacement trach #6 Shiley XLT that was open and no longer sterile in R51's bedside drawer. In an interview with E5, it was confirmed that R51's replacement trach tube was found opened, and no longer sterile. Review of other equipment with E5 revealed that there was not a size smaller trach at the bedside. E5 stated that he/she could obtain the emergency equipment from central supply, and confirmed that the resident room was lacking emergency tracheostomy supplies.</p> <p>7/16/19 12:45 PM - E5 (RN, UM) proceeded to attempt to obtain a #6 Shiley replacement trach tube.</p> <p>7/16/19 12:53 PM - E5 (RN, UM) brought a trach tube size #5 to the surveyor and stated that he/she would go to obtain a size #6 trach tube.</p> <p>7/16/19 12:58 PM - E5 (RN, UM) stated, "[He/she] is down-sizing, so I have a size #5 for [him/her]." E5 remained at the desk with the trach tube in his/her hand, and it had not been placed in the room.</p> <p>7/16/19 1:05 PM - The surveyor asked E5 (RN, UM) "Do you have a size #6 trach tube in the building?" E5 replied, "That's what I am going to find out."</p> <p>7/16/19 1:10 PM- A physician's order included: "Shiley #6 proximal XLT (trach tube)."</p> <p>7/16/19 1:10 PM - An interview with E5 (UM, RN), who began employment at the facility on</p> | F 695 | | | |

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| F 695 | <p>Continued From page 36</p> <p>12/26/18, revealed that he/she has not had any education / skills competency regarding insertion of a trach tube since employment.</p> <p>7/16/19 1:08 PM - An interview with E8 (RN) the nurse assigned to R51, who began employment at the facility on 4/9/19, revealed that he/she has not had any education/ skills competency regarding insertion of a trach tube since employment.</p> <p>7/16/19 1:15 PM - In an interview with E5 (RN, UM) and E2 (DON) it was confirmed that the facility lacked evidence of a physician's order for a trach tube size for R51 and that the facility did not have a sterile Shiley #6 trach tube and one a size smaller at the bedside.</p> <p>7/16/19 1:16 PM - An observation was made of E5 (RN, UM) supplying R51's room with the emergency size #5 and #6 trach tubes. There were no sterile replacement trach tubes in the room for one hour and nine minutes.</p> <p>7/16/19 - An untimed physician's order included: "Emergency traches (trach tubes) in bag #6 XLT."</p> <p>7/16/19 - An untimed physician's order included: "Clarify orders- Emergency trach #6 Shiley proximal XLT and #5 Shiley XLTP. Ship to hospital with both trachs to hospital."</p> <p>7/16/19 1:18 PM - In an interview with E1 (NHA) he/she informed the surveyor that the facility had "ordered back-up for the back-up to the ones (emergency trachs) that were in resident's rooms." The surveyor inquired of E1 when those back-ups were going to arrive at the building and he/she replied that he/she would have Central</p> | F 695 | | | |

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| F 695 | <p>Continued From page 37 Supply have them sent overnight.</p> <p>7/16/18 1:55 PM - E1 (NHA) reported that the order for the size of R51's trach was received "15 minutes ago".</p> <p>7/16/19 2:05 PM - E5 (RN, UM) provided the surveyor with a physician's order dated 7/16/19 at 1:10 PM for R51's #6 trach tube size.</p> <p>7/16/19 7:00 PM - A clarification physician's order included "Emergency trach #6 Shiley proxial XLT and #5 Shiley XLTP. If dislodged do not re-insert. Send resident to ER (emergency room) with both trachs."</p> <p>7/17/19 10:50 AM - An observation of R51's room revealed that on top of the treatment cart the Shiley #5 and #6 emergency replacement trach tubes remained in place.</p> <p>7/23/19 1:11 PM - In an interview with E1 (NHA), it was confirmed that R51 did not have an order prior to 7/16/19 to send R51 out to the hospital if his/her trach tube dislodged, and to not re-insert an emergency trach tube at the facility.</p> <p>The facility failed to ensure that appropriate emergency trach supplies and competent staff were available in the event of an unplanned extubation.</p> <p>7/23/19 4:30 PM- Findings were reviewed during the exit conference with E1 (NHA), E2 (DON), and E4 (RDCS)</p> <p>2. Review of R102's clinical record revealed the following:</p> | F 695 | | |

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| F 695 | <p>Continued From page 38</p> <p>3/28/19 - R102 was admitted to the facility from the hospital with diagnoses including chronic hypoxia and had a tracheostomy due to respiratory failure.</p> <p>4/8/19 (Revision date of 7/4/19) - A care plan titled tracheostomy had a goal that the patency of R102's airway will be maintained for the next 90 days. Interventions included:</p> <ul style="list-style-type: none"> - Currently capping trial (6/25/19). - Administer oxygen per physician order. - Assess respiration: note the quality, rate, rhythm, nasal flaring, use of accessory muscle. - Consult respiratory therapist. - Encourage resident to cough out secretions. - Pass Muir valve per orders. - Tracheostomy care per protocol. <p>6/25/19 - The Quarterly MDS Assessment documented that R102 scored 12 on the BIMS test, thus, was assessed as moderately impaired for her/his thinking ability.</p> <p>7/10/19 - A physician order documented:</p> <ol style="list-style-type: none"> 1) Trach ties change two times a week and PRN. 2) Trach care every shift. 3) Inner cannula (Trach tube) changed twice a day and PRN. 4) Suction PRN. 5) Compressor on 40 and Neb (nebulizer) bottle on 50 and concentrator on 2 L/M = 28% (Settings on a respiratory system to deliver oxygenation at 2 L/M). 6) Emergency traches (sic) in bag #4 Shiley. 7) Trach #4 Shiley changed monthly. 8) Weaned and capping 24/7 on 2 L/M. <p>7/16/19 from 12:47 PM to 12:59 PM - A joint observation of R102's room with E2 (DON) and</p> | F 695 | | | |

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| F 695 | <p>Continued From page 39</p> <p>E5 (RN, UM) revealed R102 in bed with his/her trach tube intact and with a cap. An Ambu bag was located hanging in a plastic bag at R102's bedside. E2 and E5 proceeded to locate the replacement trach tube by searching R102's bedside cabinet drawers and R102's closet. At 12:51 PM, the surveyor inquired if the tube may be located in the facility's Central Supply Room. In response to the surveyor's comment, both E2 and E5 exited R102's room and proceeded to the Central Supply Room, where E2 and E5 consulted with E36 (MR). Shortly thereafter, the trach tube was secured in the Central Supply Room by E2 and E5.</p> <p>7/16/19 1:00 PM - The replacement trach with the same size and style was placed in a plastic bag and placed at R102's bedside.</p> <p>7/16/19 1:05 PM - An interview with E7 (RN), who was assigned to R102, revealed that he/she began employment at the facility earlier this year (2019) and has not had any education / skills competency regarding insertion of a trach tube since employment.</p> <p>7/16/19 1:10 PM - An interview with E5 (UM, RN), who began employment at the facility on 12/26/18, revealed that he/she has not had any education / skills competency regarding insertion of a trach tube since employment.</p> <p>7/16/19 3:50 PM - An interview with E30 (RRT) revealed that replacement of a trach tube should be completed by a licensed nurse that was provided both education and demonstrated competency for trach tube insertion.</p> <p>7/16/19 4:00 PM - A physician ordered trach</p> | F 695 | | | |

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| F 695 | <p>Continued From page 40</p> <p>stoma care (frequency was not included in this order), pulse oximetry every 4 hours for 24 hours and every shift, and to remove all trach supplies 24 hours later.</p> <p>7/16/19 5:00 PM - A Respiratory Note, by E30 (RRT) documented that R102 was receiving 2-4 L/M of oxygen and R102's oxygen saturation was 94% prior to removal (decannulated) of the trach tube on 7/16/19. After decannulation, R102 had no shortness of breath or incidents at the time of the decannulation. Recommendations included 1) 24 hours later remove all trach supplies 2) every 4 hours checking pulse oximetry for 24 hours then every shift 3) Trach stoma care.</p> <p>The facility failed to ensure that the physician's order dated 7/10/19 was followed, which indicated to have "... emergency traches in bag #4 Shiley...", R102's emergency equipment.</p> <p>7/17/19 3:17 PM - An interview with E71 (Clerk/Scheduler) revealed, that late yesterday afternoon, on 7/16/19, he/she was provided a list of licensed nurses who had completed their education and competency for insertion of a trach tube on 7/16/19 and was instructed by E1 (NHA) to use this list to schedule the licensed nursing staff effective 7/17/19. In addition, E71 was instructed to call the licensed nurses, who were not on the list and to tell them that they must complete the education and competency before they are scheduled to work. E71 confirmed prior to 7/17/19, in scheduling licensed nurses, E71 did not have any list of nurses who had education or competency for insertion of a trach tube.</p> <p>The facility failed to have a system in place, when scheduling a licensed nurse for each shift, to</p> | F 695 | | | |

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| F 695 | <p>Continued From page 41</p> <p>ensure which nurse(s) were educated and had completed competencies for accidental trach decannulation prior to 7/17/19.</p> <p>7/18/19 3:00 PM - An interview with E1 (NHA) confirmed that the above policy and procedure failed to include that only licensed nurses, who had completed both education and competencies for trach insertion were permitted to perform this intervention. Furthermore, E1 verbalized that the expectation was to have education and competency completed at the time of orientation for new employees and annually thereafter. E1 confirmed that new nurses hired have not had the education and competency, however, it was E1's opinion that the facility had an adequate number of staff who were competent to insert a trach tube. During this interview, the surveyor informed E1 that of the current 30 licensed nurses, 15 (50%) lacked evidence of education and competency, including the licensed nurses assigned to R51 (E8/RN) and to R102 (E7/RN) during the day shift (7:00 AM to 3:00 PM) on 7/16/19. Additionally, the RN, Unit Manager (E5/RN), who was working during the day shift, where both R51 and R102 resided lacked evidence of education and competency.</p> <p>The facility failed to ensure:</p> <ul style="list-style-type: none"> - appropriate sized trach tubes were available at the bedside for residents (R51 and R102) with tracheostomies. - an established system, when scheduling a licensed nurse for each shift, as to which nurses were educated with demonstrated competency for accidental trach decannulation for scheduling purposes. - an established system to ensure only licensed nurses with education and competency were | F 695 | | | |

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| F 695 | Continued From page 42 assigned to those residents with tracheostomies in the event of an emergency, including accidental trach decannulation. | F 695 | | | |
| F 697 SS=D | Findings were reviewed with E1 (NHA) and E2 (DON) during the Exit Conference on 7/23/19 beginning at approximately 4:30 PM. Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews, it was determined that the facility failed to ensure that pain management was provided to residents who require such services, consistent with professional standards of practice, the comprehensive person - centered care plan, and the resident's goals and preferences for one (R75) out of one sampled resident reviewed for pain management. Findings include: Review of R75's clinical record revealed the following: 6/6/19 - R75 was admitted to the facility with diagnoses that included chronic pain syndrome. 6/6/19 - A physician's order stated R75 that was to receive the medication Acetaminophen 500 mg (milligram) 1 tablet by mouth every 6 hours for pain with administration times at 6:00 AM, 12:00 | F 697 | F697D - Pain Management Step 1: R75 pain was assessed with no adverse findings noted. A medication error report completed and the physician and responsible party made aware. Step 2: Residents requiring pharmacologic pain management have the potential to be affected. The DON and/or designee reviewed the Medication Administration Record (MAR) for current residents receiving pharmacologic pain management to ensure medication is being provided as ordered. Where necessary, a medication error report completed and the physician and responsible party made aware. | 8/22/19 | |

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| F 697 | Continued From page 43 PM, 6:00 PM and 12:00 AM. 6/13/19 - A care plan for pain stated the goal was for R75 to express his/her pain level within satisfactory limits. Interventions included, but were not limited to: administer pharmacological interventions as indicated per the physician and monitor effectiveness and assess verbal and nonverbal signs and symptoms relating to pain: grimacing, guarding, crying, moaning, increased anxiety. 7/18/19 at 12:16 PM - Review of R75's July 2019 MAR (Medication Administration Record) revealed that 3 doses of the 6:00 PM Acetaminophen were not signed off as administered on July 7, 15 and 16, 2019. 7/23/19 at 2:00 PM - During an interview, E2 (DON) confirmed the findings. The facility failed to ensure that pain management was provided to R75, who required such services, consistent with professional standards of practice, the comprehensive person - centered care plan, and the resident's goals and preferences. Findings were reviewed with E1 (NHA), E2, and E4 (Regional Director of Clinical Services) during the Exit Conference on 7/23/19 beginning at approximately 4:30 PM. | F 697 | Step 3: To prevent the potential for reoccurrence the DON and/or designee will educate licensed nursing staff on pain medication administration with emphasis on signing out delivered medicine on the MAR when completed. Step 4: To monitor and maintain ongoing compliance the DON and/or designee will review 10 residents receiving pharmacologic pain management for completed MARs 1 time weekly for 3 months until 100 percent compliant. Results will then be reported to QAPI committee for further review and recommendations. | | |
| F 698 SS=D | Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent | F 698 | | 8/22/19 | |

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| F 698 | <p>Continued From page 44</p> <p>with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, it was determined that the facility failed to ensure that residents who required dialysis services received such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences for one (R40) out of one sampled residents. Findings include:</p> <p>Review of R40's clinical record revealed the following:</p> <p>7/26/06 - R40 was admitted to the facility with diagnoses such as End Stage Renal Disease (ESRD).</p> <p>5/13/19- A care plan was implemented stating that R40 needed hemodialysis related to renal failure via a left AV fistula. Interventions included to assess, document, and report to the physician, as needed, any signs and symptom of infection to R40's access site.</p> <p>6/24/19-6/30/19- Review of R40's MDS assessments revealed that R40 discharged to the hospital on 6/24/19 and returned to the facility on 6/30/19.</p> <p>6/2019- Review of R40's physician orders after return from the hospital revealed that R40 had an order to monitor his/her dialysis site for bleeding.</p> <p>7/2/19 1:10 PM- A physician's progress note stated that during R40's hospitalization he/she</p> | F 698 | <p>F698D - Dialysis</p> <p>Step 1: R40 tunneled dialysis chest wall catheter is now monitored and observations are documented.</p> <p>Step 2: Residents with dialysis chest wall catheters have the potential to be affected. The DON and/or designee observed documentation for all residents with dialysis chest wall catheters to ensure they are being monitored. Where necessary the catheter site was observed, and documentation created.</p> <p>Step 3: To prevent the potential for reoccurrence the DON and/or designee will educate licensed nursing staff on dialysis chest wall catheter monitoring with emphasis on documentation.</p> <p>Step 4: To monitor and maintain ongoing compliance the DON and/or designee will review the documentation for residents with dialysis chest wall catheters for completion 1 time weekly for 3 months until 100 percent compliant. Results will be reported to QAPI committee for further review and recommendations.</p> | | |

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| F 698 | Continued From page 45 was noted to have an ulceration to his/her AV fistula. R40 required a partial resection to his/her AV fistula and a repair that was completed on 7/27/19 by vascular surgery. It was noted that R40 currently had a tunneled dialysis catheter in place for dialysis. 7/2/19-7/17/19- Review of R40's eTAR revealed that staff were not documenting monitoring R40's new tunneled dialysis catheter site. 7/18/19- A physician's order was placed to monitor R40's tunneled dialysis catheter site for bleeding. The facility failed to ensure that R40, a resident who required dialysis services, received such services, as evidenced by the facility failed to monitor R40's new tunneled dialysis catheter after she was admitted back from the hospital on 6/24/19 until 7/17/19. 7/23/19 4:30PM- Findings were reviewed during the exit conference with E1 (NHA), E2 (DON), and E4 (RDSCS). | F 698 | | | |
| F 710 SS=D | Resident's Care Supervised by a Physician CFR(s): 483.30(a)(1)(2) §483.30 Physician Services A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. A physician, physician assistant, nurse practitioner, or clinical nurse specialist must provide orders for the resident's immediate care and needs. §483.30(a) Physician Supervision. | F 710 | | 8/22/19 | |

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| F 710 | <p>Continued From page 46</p> <p>The facility must ensure that-</p> <p>§483.30(a)(1) The medical care of each resident is supervised by a physician;</p> <p>§483.30(a)(2) Another physician supervises the medical care of residents when their attending physician is unavailable. This REQUIREMENT is not met as evidenced by: Based on interview and clinical record review, it was determined that for two (R35 and R92) out of four sampled residents, the facility failed to ensure the attending physician supervised the resident's medical care, specifically medical issues related to the resident's weight changes. Findings include:</p> <p>1. Review of R35's clinical record revealed:</p> <p>7/29/16- R35 was admitted to the facility with diagnoses that included Alzheimer's dementia.</p> <p>R35's documented weights (in pounds) were as follows:</p> <p>1/5/19 191.0; 2/13/19 183.4 ; 3/10/19 177.2 (standing); 3/22/19 175.2; 4/2/19 183.5; 5/2/19 171.2; 5/13/19 166.2; 5/15/19 171 (standing).</p> <p>5/20/19 6:09 PM- A nutritional progress note written by E65 (Dietician) stated that the 5/6/19 annual MDS was modified to show a significant weight change. R35 was noted with weight</p> | F 710 | <p>F 710D Resident Care Supervised by a Physician</p> <p>Step 1: R35 and R92 s weights were evaluated and addressed by their individual physician.</p> <p>Step 2: Residents demonstrating a significant weight change have the potential to be affected. The DON and/or designee reviewed current residents with significant weight changes to ensure they have been evaluated and addressed by the physician.</p> <p>Step 3: To prevent this from recurring the DON/designee will educate licensed nursing staff on significant weight changes with emphasis on reporting them to the physician when observed. NHA/designee will educate Physicians/extenders on evaluating and addressing weight changes.</p> <p>Step 4: To monitor and maintain ongoing</p> | | |

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| F 710 | <p>Continued From page 47</p> <p>variations recently, and R35 experienced a significant weight loss of 6.70% from 4/2/19 to 5/2/19.</p> <p>5/22/19- A physician's progress note written by an NP stated that weight gain or loss was absent.</p> <p>6/12/19- R35's weight was 168.6; this reflected an 11.36% weight loss in 6 months.</p> <p>6/13/19 5:17 PM- A physician progress note was written by E68 (NP) and there was no evidence that E68 was assessed or that E68 was aware of R92's significant weight change.</p> <p>6/26/19- A physician's progress note written by an NP stated that weight gain or loss was absent.</p> <p>7/2/19- R35's weight was 157.8; this reflected an 6.41% weight loss in 1 month.</p> <p>7/12/19 at 1:11 PM- R35 was observed at lunch in the main dining room. R35 did not eat any of his/her lunch.</p> <p>7/18/19 at 3:34 PM- During an interview, E66 (Corporate Dietitian) stated he/she would have expected to see supplements added to R35's diet with the documented weight loss.</p> <p>7/22/19 at 10:14 AM- During an interview, E65 (Dietician) stated the nutritional interventions for R35 were to review weights weekly, to review meal intake, and to assess for any contributing factors such as edema. E65 stated that R35's weight loss from 183.5 pounds on 4/2/19 to 157.8 pounds on 7/2/19 (a 14.1% weight loss in 3 months) was flagged in the electronic medical record.</p> | F 710 | <p>compliance the DON and/or designee will review 5 residents with significant weight changes to ensure physician notification, physician/extender evaluated and addressed weight changes has occurred 1 time weekly for 3 months until 100 percent compliant. Results will then be reported to QAPI committee for further review and recommendations.</p> | | |

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| F 710 | <p>Continued From page 48</p> <p>Review of R35's physician orders revealed no physician orders for nutritional supplements.</p> <p>The facility failed to ensure R35's significant weight loss was evaluated and addressed by the physician.</p> <p>Findings were reviewed with E1 and E2 on 7/23/19 at 4:30 at exit conference.</p> <p>2. Review of R92's clinical record revealed:</p> <p>6/17/16- R92 was admitted to the facility.</p> <p>6/8/19 to 6/12/19- Review of R92's weights revealed that he/she had an increase in weight from 220 lbs on 6/8/19 to 236.8 lbs on 6/12/19. This was a significant weight gain of 7.64%.</p> <p>6/13/19 5:17 PM- A physician progress note was written by E68 (NP) and there was no evidence that E68 assessed or was aware of R92's significant weight change.</p> <p>7/1/19-7/10/19- Review of R92's weights revealed that on 7/1/19 R92's weight was 227.7 lbs and decreased to 195.6 lbs on 7/10/19, a weight decrease of 14.10%.</p> <p>7/11/19 9:36 PM- A physician progress note was written by E69 (Physician) and there was no evidence that E69 assessed or was aware of R92's significant weight change.</p> <p>7/17/19 8:38 PM- A physician progress note was</p> | F 710 | | | |

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| F 710 | Continued From page 49 written by E68 (NP) and there was no evidence that E68 assessed or was aware of R92's significant weight change. 7/19/19- Review of R92's weights revealed that a reweight was completed, over a week after the significant weight decline on 7/1/19, and stated that R92 weight was 195.8 lbs. The physician failed to supervise and assess R92's significant weight changes when he/she had a significant weight gain of 7.64% on 6/12/19 and had a significant weight decrease of 14.10% on 7/10/19. 7/23/19 4:30 PM- Findings were reviewed during the exit conference with E1 (NHA), E2 (DON), and E4 (RDGS). | F 710 | | | |
| 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 | F 756 | | 8/22/19 | |

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| F 756 | <p>Continued From page 50</p> <p>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 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.</p> <p>§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:</p> <p>Based on clinical record review and interview, it was determined that the facility failed to act on irregularities identified during medication regimen reviews (MRRs) by the pharmacist, and failed to ensure that all MRR recommendations were signed by the physician for 2 (R49 and R81) out of 7 residents sampled. Additionally, the facility failed to develop policies and procedures for the monthly MRR that included, but not were limited to, time frames for different steps in the MRR process and steps the pharmacist must take when he or she identified an irregularity that required urgent action to protect the resident. Findings include:</p> <p>1. Review of R49's clinical record revealed:</p> | F 756 | <p>F 756D - Drug Regime Review</p> <p>Step 1: R49 and R81 s Medication Regimen Review (MRR) was addressed by the physician. The facility had a policy in place and it was updated.</p> <p>Step 2: Residents taking medication have the potential to be affected. The DON and/or designee reviewed the current MRR for all residents to ensure physician review and follow up was evident. Where necessary, the MRR was acknowledged and addressed by the doctor.</p> <p>Step 3:</p> | | |

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| F 756 | <p>Continued From page 51</p> <p>On 5/9/19 an MRR recommended that R49 receive a fasting lipid panel the next convenient day and every 12 months thereafter. This recommendation was not signed by the attending physician. The facility provided documentation that a fasting lipid panel was ordered by the nurse practitioner on 6/18/19, however, there was no documentation regarding the recommendation that R49 have this test every 12 months.</p> <p>On 7/23/19 at 1:20 PM, during an interview, E2 (DON) stated that the facility did not have a written policy or process regarding the consultant pharmacist recommendations.</p> <p>The facility failed to ensure that the attending physician documented in the resident's medical record that the identified irregularity was reviewed and what, if any, action had been taken to address it. Additional, the facility failed to develop written policies and procedures for the monthly drug regimen review.</p> <p>Findings were reviewed with E1 (NHA), E2 (DON) and E4 (RDSCS) during the exit conference on 7/23/19 at 4:30 PM.</p> <p>2. Review of R81's clinical record revealed the following:</p> <p>6/19/19 - The facility pharmacist documented on the monthly Medication Regimen Review (MRR) to "see report for any noted irregularities and/or recommendations."</p> | F 756 | <p>To prevent the potential for reoccurrence the Regional Director of Clinical Services will educate the DON on the MRR policy. The DON and/or designee will educate licensed nursing staff on the MRR policy.</p> <p>Step 4: To monitor and maintain ongoing compliance the DON and/or designee will review all current resident MRRs for physician acknowledgment and action 1 time monthly for 100 percent compliance for 3 months, then quarterly. Results will then be reported to QAPI committee for further review and recommendations.</p> | | |

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| F 756 | Continued From page 52 6/19/19 - The report included a recommendation to clarify the diagnosis and to document a stop date for an antibiotic that R81 was prescribed. There was lack of evidence that the recommendation was reported to R81's attending physician and/or acted upon. 7/23/19 3:20 PM - An interview with E2 (DON) revealed that he/she was unable to locate evidence that the recommendation was reported to R81's attending physician and/or acted upon. The facility failed to ensure that the pharmacist reported any irregularities and that the reports were acted upon. Findings were reviewed with E1 (NHA) and E2 (DON) during the Exit Conference on 7/23/19 beginning at approximately 4:00 PM. | F 756 | | | |
| F 758 SS=D | 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 | F 758 | | 8/22/19 | |

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| F 758 | <p>Continued From page 53</p> <p>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;</p> <p>§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;</p> <p>§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</p> <p>§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 beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.</p> <p>§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 interview and clinical record review, it was determined that for one R2)out of seven (7) sampled residents for unnecessary medication review, the facility failed to identify target behaviors for a diagnosis of delusional disorder, and failed to monitor for those behaviors. The</p> | F 758 | <p>F 758D - Free from Unnec Psychotropic Meds/PRN Use</p> <p>Step 1: The facility in May 2019 completed an audit regarding all psychotropic</p> | | |

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| F 758 | <p>Continued From page 54</p> <p>facility failed to have an indication for the use of Risperdal(antipsychotic medication)on the April and June 2019 monthly orders. Findings include:</p> <p>The following was reviewed in R2's clinical record:</p> <p>11/7/17 - R2 was admitted to the facility with COPD and dementia</p> <p>11/24/19 - A physician's order included "Lexapro 5 mg once a day for depression."</p> <p>3/6/19 - A physician's order included "Risperdal 0.25 milligrams by mouth in the morning and Risperdal 0.5 milligrams by mouth at bedtime."</p> <p>3/6/19, 6/6/19 and 6/12/19 - Consult progress notes written by E35 (MD, Psych) revealed mild delusional disorder as an indication for use of the medication Risperdal.</p> <p>4/17/19 - A physician's order included "Discontinue morning dose of Risperdal. Continue bedtime dose."</p> <p>April, May, and June, 2019 of R2's medical record included monitoring for depression related to sadness/withdrawn/tearful, and monitoring for side effects of Lexapro. The resident record lacked evidence of behavior and side effect monitoring for R2's Risperdal related to his/her delusional disorder.</p> <p>4/2019 -R2's April monthly orders lacked documentation of an indication for use of Risperdal.</p> <p>5/2019 - Handwritten on R2's May monthly orders</p> | F 758 | <p>medications of current resident a Performance Improvement Plan was implemented during this audit. R2's medication was noted to lack monitoring of behavior/side effects and indication for use. After discussing with physician a GDR was initiated and medication was discontinued on 6/6/19.</p> <p>Step 2: Residents utilizing antipsychotic drugs have the potential to be affected. The DON and/or designee reviewed current residents receiving antipsychotic medication for indication of use, target behavior and side effects.</p> <p>Step 3: To prevent the potential for reoccurrence the DON and/or designee will educate nursing on antipsychotic medications with emphasis on indication for use, target behaviors, and side effects.</p> <p>Step 4: To monitor and maintain ongoing compliance the DON and/or designee will review 5 residents taking antipsychotic medication for identified target behaviors and evidence of side effect monitoring 1 time weekly for 3 months until 100 percent compliant. Results will then be reported to QAPI committee for further review and recommendations.</p> | | |

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| F 758 | Continued From page 55 was an indication of psychosis for the use of Risperdal. 6/2019 -R2's June monthly orders lacked documentation of an indication for the use of Risperdal. 6/6/19 - R2's Risperdal and Lexapro were discontinued. 7/23/19 9:27 AM - In an interview with E11 (RN) he/she confirmed that the record lacked evidence of monitoring for delusions or for the side effects of Risperdal for the months of April, May and June 2019. E11 also confirmed that there was not an indication for use of the medication Risperdal on the monthly orders for April or June of 2019. The facility failed to identify R2's targeted behaviors and failed to monitor for those behaviors and side effects of an anti-psychotic medication. The facility also failed to identify an indication for use of R2's anti-psychotic medication on the monthly orders for April and June of 2019. Findings were reviewed with E1 (NHA), E2 (DON) and E4 (RDSCS) during the exit conference on 7/23/19 at 4:30 PM. | F 758 | | | |
| F 791 SS=D | Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- | F 791 | | 8/22/19 | |

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| F 791 | <p>Continued From page 56</p> <p>§483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services;</p> <p>§483.55(b)(2) 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 locations;</p> <p>§483.55(b)(3) 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;</p> <p>§483.55(b)(4) 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; and</p> <p>§483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that for one (R29) out</p> | F 791 | F 791D - Routine/Emergency Dental Srvcs in NF s | |

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| F 791 | <p>Continued From page 57</p> <p>of one sampled residents, the facility failed to provide the opportunity for routine dental services. Findings include:</p> <p>Review of R29's clinical record revealed:</p> <p>Review of R29's Personal Effects Inventory sheet dated 4/25/12, revealed R29 had no dentures on her original admission into the facility.</p> <p>On 3/15/18 a dental consultation report requested a dental follow up for R29.</p> <p>R29 was re-admitted to the facility from the hospital on 4/16/19 with diagnoses that included Alzheimer's dementia, bipolar disorder, and schizoeffective disorder.</p> <p>On 4/23/19, a significant change MDS indicated that R29 had moderate cognitive impairment and had no natural or broken teeth.</p> <p>On 7/12/19 at 11:44 AM, R29 was observed with no teeth.</p> <p>On 7/12/19 at 11:45 AM, during an interview, R29 stated that he/she had misplaced his/her teeth but he/she didn't remember when.</p> <p>On 7/16/19 at 11:52 AM, during an interview E70 (SW), stated that the facility changed dental providers after R29's 2018 dental consult. E70 stated there was no dental follow up provided for R29, and he/she would enroll R29 in the new dental program.</p> | F 791 | <p>Step 1: R29 has consult scheduled with dentist.</p> <p>Step 2: residents provided the opportunity for dental services have the potential to be affected. The Social Worker (SW) reviewed current residents with to ensure they were provided with the opportunity for dental services. Those residents wishing dental services are addressed.</p> <p>Step 3: To prevent this from recurring the Nursing Home Administrator (NHA) and/or designee will educate the SW on providing the opportunity for dental service.</p> <p>Step 4: To monitor and maintain ongoing compliance the NHA will review 5 residents provided the opportunity for dental service to ensure they have been addressed, weekly for 3 months until 100 percent compliant. Results will then be reported to QAPI committee for further review and recommendations</p> | | |
| F 812 SS=E | Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) | F 812 | | 8/22/19 | |

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| F 812 | Continued From page 58 §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and interview, it was determined that the facility failed to properly store, prepare, and maintain personal hygiene to ensure food safety. Findings include: 1. The following were observed during the initial tour on 7/11/19 from 8:00 AM to 8:45 AM: - The top of the shelf at the trayline was dusty where the staff stored the temp logs and thermometer; - The soda dispenser near the coffee station was sitting in stagnant water without sanitizer; - There was an uncovered Styrofoam cup with unlabeled brown colored fluid located next to the coffee station; - There were no test Quaternary Ammonia sanitizer strips for the 3-compartment sink to test | F 812 | F 812E - Food Procurement, Store/Prepare/Serve-Sanitary Step 1: Shelf above tray line cleaned. Paper Towel dispenser filled immediately. Juice Dispenser gun removed from pitcher and cleaned. Walk in Refrigerator repaired. Food of questionable temperature discarded. Testing supplies and logs made available to staff for three compartment sink. Coffee cup removed. Carton of milk discarded. Bread discarded. Refrigerator was repaired. All food was discarded from refrigerator. | | |

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| F 812 | <p>Continued From page 59</p> <p>sanitizer levels;</p> <ul style="list-style-type: none"> - There were no paper towels for hand drying near the 3 compartment sink hand washing station; - There was 1 carton of milk with an expiration date of "7/10/19" in the dairy fridge by the trayline; - The bags of bread on the bread storage cart had various expiration dates ranging from "7/1/19" - "7/10/19". <p>2. On 7/11/19 at approximately 8:45 AM, it was observed that the walk-in refrigerator ambient temperature was 50 F. Upon further investigation, the following were observed inside of the walk-in refrigerator:</p> <ul style="list-style-type: none"> - The walk-in refrigerator condenser was frozen, and there was not sufficient evidence that maintenance interventions were provided by the facility to remedy the issue; - The walk-in refrigerator gasket was in disrepair; - There was an open pack of unidentified deli meat with the date marked on "6/16/19"; - There was a box of creamer with an expiration date of "6/24/19"; - The melted ice from the refrigerator condenser was dripping on various food items including tomatoes, lettuce, cheese, creamer, and meats; - There was a pool of melted ice water from the refrigerator condenser pooling on the floor of the walk-in refrigerator; - Temperatures taken by E27 (Food Service Director) witnessed by 2 surveyors for potato salad and cole slaw on 7/11/19 at approximately 8:48 AM were 47 F; - Temperatures taken by E27 witnessed by 2 surveyors for creamer, a second package of cole slaw, and tuna salad on 7/11/19, at approximately 8:48 AM, were 48 F. | F 812 | <p>Step 2: Current residents that have the potential to be affected. The NHA and/or designee conducted sanitation rounds in the kitchen. Where necessary, corrections were made to ensure compliance with sanitation guidelines.</p> <p>Step 3: To prevent the potential for reoccurrence the NHA and/or designee will educate the kitchen staff on the policy of how to obtain temperatures of food; acceptable food temperatures and to discard food of questionable temperature, and how to ensure kitchen sanitation is maintained. NHA and/or designee also educated kitchen staff on the use of test strips for sanitizer potency in the three compartment sink. NHA/designee will educate staff on dating and labeling food for proper food storage.</p> <p>Step 4: To monitor and maintain ongoing compliance the NHA and/or designee will observe the kitchen for shelf cleanliness, paper towel availability, sanitary juice dispenser gun storage, and that no personal items are stored in food prep areas. NHA and/or designee will also monitor that the walk-in refrigerator is in working order and maintaining temperature. NHA and/or designee will ensure sanitizer testing supplies are available and are logs being used for three compartment sink. Food will be observed to ensure it is used before</p> | | |

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| F 812 | Continued From page 60 Findings were reviewed and confirmed by E1 (NHA) and E27 during the kitchen tour. All foods in the walk-in refrigerator were disposed of by 7/11/19 at approximately 12:15 PM. | F 812 | expiration date. Observation will occur at random times 5 times weekly for 2 weeks to ensure 100% compliance. Observation will then occur 1 time weekly for 2.5 months to ensure 100% compliance is maintained. Results will be reported to QAPI committee for further review and recommendation. | | |
| F 883 SS=D | 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. | F 883 | | 8/22/19 | |

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| F 883 | <p>Continued From page 61</p> <p>§483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-</p> <p>(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;</p> <p>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;</p> <p>(iii) The resident or the resident's representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:</p> <p>(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and</p> <p>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, it was determined that the facility failed to ensure that medical records included documentation of the influenza immunization for one (R92) out of 5 sampled residents for immunization record review. Findings include:</p> <p>Review of R92's clinical record revealed:</p> <p>6/17/16 - R92 was admitted to the facility.</p> <p>10/20/18 - R92 signed a consent to receive the</p> | F 883 | <p>F 883 Influenza and Pneumococcal Immunizations</p> <p>Step 1: R92 medication error report generated. Physician and responsible party made aware.</p> <p>Step 2: Residents admitted to the Center during the 2018-2019 flu season have the potential to be affected. The DON and/or</p> | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/13/2019
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085039 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 07/23/2019 |
|--|---|---|--|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER NEW CASTLE HEALTH AND REHABILITATION CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 32 BUENA VISTA DRIVE NEW CASTLE, DE 19720 | | |
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| F 883 | <p>Continued From page 62 influenza vaccine.</p> <p>10/20/18 at 3:15 PM - A nursing progress note documented that R92's flu vaccine was not administered due to an elevated temperature.</p> <p>7/23/19 at 1:16 PM - During record review, there was no documentation to show that R92 received the influenza immunization after October 20, 2018.</p> <p>7/23/19 at 3:21 PM - During an interview, E2 (DON) confirmed that there was no follow up documentation regarding R92's influenza immunization status after October 20, 2018.</p> <p>Findings were reviewed with E1 (NHA), E2 (DON), and E3 (Regional Director of Clinical Services) during the Exit Conference on 7/23/19 beginning at approximately 4:30 PM.</p> | F 883 | <p>designee reviewed residents with consent to receive the flu vaccine for evidence of administration. Where necessary, a medication error report will be generated and the physician and responsible party made aware</p> <p>Step 3: To prevent the potential for reoccurrence the DON and/or designee will educate licensed nursing staff on administration of flu vaccine with emphasis on receiving follow up orders from the physician if administration is medically contraindicated.</p> <p>Step 4: To monitor and maintain ongoing compliance the DON/Designee will review newly signed consent for flu vaccination against documentation of administration 1 time weekly for 3 months, upon the initiation of the 2019-2020 flu season, until 100 percent compliant. Results will then be reported to QAPI committee for further review and recommendations</p> | | |



**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: New Castle Rehabilitation DATE SURVEY COMPLETED: July 23, 2019

| SECTION | STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES | ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES | COMPLETION DATE |
|---|---|---|--|
| <p>3201</p> <p>3201.1.0</p> <p>3201.1.2</p> | <p>The State Report incorporates by reference and also cites the findings specified in the Federal Report.</p> <p>An unannounced annual, complaint, emergency preparedness, and extended surveys were conducted at this facility from July 11, 2019 to July 23, 2019. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census the first day of the survey was 107. The survey sample size was 45.</p> <p>For the Emergency Preparedness survey, all contracts, operations plan, contact information, and annual emergency drills were up to date. No deficiencies were identified.</p> <p>Regulations for Skilled and Intermediate Care Facilities</p> <p>Scope</p> <p>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.</p> <p>This requirement is not met as evidenced by: Cross Refer to the CMS 2567-L survey completed July 23, 2019: F656, F657, F677, F684, F688, F689, F692, F693, F695, F697, F698, F710, F756, F758, F791, F812 and F883.</p> | <p>Preparation and submission of this Plan of Correction does not constitute an admission of or agreement with, it is required by State and Federal Law. It is executed and implemented as a means to continuously improve the quality of care to comply with State and Federal requirements.</p> <p>Cross Refer to the CMS 2567 POC:</p> <p>F656 F657 F677 F684 F688 F689 F692 F693 F695 F697 F698 F710 F756 F758 F791 F812 F883</p> | <p>8/22/19 8/22/19 8/22/19 8/22/19 8/22/19 8/22/19 8/22/19 8/22/19 7/24/19 8/22/19 8/22/19 8/22/19 8/22/19 8/22/19 8/22/19 8/22/19 8/22/19</p> |

Provider's Signature 

Title Administrator

Date 9/10/19