

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

PRINTED: 12/23/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085041	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/21/2019
NAME OF PROVIDER OR SUPPLIER DELMAR NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 101 E. DELAWARE AVENUE DELMAR, DE 19940		
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E 000	Initial Comments An unannounced annual and complaint survey was conducted at this facility from October 14, 2019 through October 21, 2019. The facility census the first day of the survey was 90. During this period an Emergency Preparedness Survey was also conducted by the State of Delaware's Division of Health Care Quality Long Term Care Residents Protection in accordance with 42 CFR 483.73. For the Emergency Preparedness survey, no deficiencies were cited.	E 000			
F 000	INITIAL COMMENTS An unannounced annual and complaint survey was conducted at this facility from October 14, 2019 through October 21, 2019. The deficiencies contained in this report are based on observation, interviews, review of residents' clinical records and other facility documentation as indicated. The facility census the first day of the survey was 90. The survey sample totaled forty (40). Abbreviations/Definitions used in this report are as follows: AD - Activities Director; ADON - Assistant Director of Nursing; CNA - Certified Nurse's Aide; COTA - Certified Occupational Therapy Aide; DON - Director of Nursing; FSD - Food Service Director; IDT - Interdisciplinary Team; LPN - Licensed Practical Nurse; MD - Medical Doctor; NHA - Nursing Home Administrator; PT - Physical Therapist;	F 000			

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

TITLE

(X6) DATE

Electronically Signed

11/12/2019

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	Continued From page 1 RN - Registered Nurse; RNAC - MDS Coordinator, Registered Nurse Assessment Coordinator; SW - Social Worker; UM - Unit Manager; Adjustment disorder - a group of symptoms, such as stress, feeling sad or hopeless, and physical symptoms that can occur after going through a stressful life event; Anxiety disorder - mental illness that cause constant fear and worry; Aseptic - prevents the spread of infection; free of harmful germs; Auscultation - to listen to body sounds with a stethoscope; Bipolar disorder - a serious mental illness characterized by extreme mood swings; 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; cm (centimeter) - a unit of measurement; Dementia - term for diseases and conditions characterized by a decline in memory, judgement, language, problem-solving and other thinking skills that affect a person's ability to perform everyday activities; Aseptic - prevents the spread of infection; free of harmful germs; EMR - Electronic Medical Record; G-tube - Gastrostomy tube - A feeding tube used to provide nutrition to people who cannot obtain nutrition by mouth, are unable to swallow safely, or need nutritional supplementation; e.g - for example; Gastric tube - tube going directly into the stomach	F 000			

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F 000	Continued From page 2 for feeding; IV - intravenous; Liters - unit of measurement; Major depression disorder - mental health disorder having episodes of depression; MAR - Medication Administration Record, list of medications to be administered with nurse, time and date given; MDS - Minimum Data Set (standardized assessment forms used in nursing homes); mg - milligram, unit of weight; MIC-KEY Button G (gastric) feeding tube - type of feeding tube used to provide nutrition to people who cannot obtain nutrition by mouth, are unable to swallow safely, or need nutritional supplementation; mL - milliliter, unit of liquid measurement; Nasal cannula - tube placed into nostrils to deliver oxygen; PASARR - Preadmission Screening and Resident Review; po - by mouth, oral; PRN - as needed; PT - physical therapy; Schizophrenia - mental disorder with false beliefs of being harmed; Schizoaffective disorder - a mental disorder in which a person experiences a combination of schizophrenia and mood disorder symptoms; Vancomycin - an antibiotic medication used to treat infections; Zosyn - an antibiotic medication used to treat infections.	F 000			
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence,	F 550		12/16/19	

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F 550	<p>Continued From page 3</p> <p>self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.</p> <p>§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.</p> <p>§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.</p> <p>§483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.</p> <p>§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.</p> <p>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by:</p>	F 550			

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F 550	<p>Continued From page 4</p> <p>Based on a random observation, it was determined that the facility failed to ensure R29 was treated with dignity and respect when a CNA was observed responding to R29 in a loud voice, while laughing repeatedly, speaking a language in which R29 was not fluent and asking R29 if there was a need to go to the bathroom loudly while in the common area. Findings include:</p> <p>Review of R29's clinical record revealed the following:</p> <p>5/15/19 - A care plan for communication was initiated, with the problem of making self understood by others. Spanish is the primary language. Interventions included in the care plan were to allow adequate time for comprehension, provide adequate time for resident to initiate or respond to communication from others, use short direct phrases, evaluate any acute or transitory conditions resulting in decreased hearing, and monitor for diseases/conditions and medications which could potentially affect communication if indicated.</p> <p>8/14/19 - A quarterly MDS assessment documented that R29 had minimal hearing difficulty, with limited ability to make self understood and understand others and sometimes responds to adequate simple, direct communication only.</p> <p>10/14/19 - During random observations from 12:45 PM through 1:45 PM the following interactions occurred:</p> <p>12:45 PM -1:30 PM - R29 had visitors in and all were observed sitting in the unit seating area eating strawberries and speaking in a typical</p>	F 550	<p>Corrective Measures for residents affected:</p> <p>Staff members that were working at the time of the noted incident with resident R29 were provided with education related to Resident Rights, Communication, and language services.</p> <p>Identification of others with the potential to be affected:</p> <p>All facility residents have the potential to be affected.</p> <p>Measures to prevent recurrence:</p> <p>All facility staff members to be educated on Resident Rights, Communication, and language services. (Exhibit 1).</p> <p>Monitoring of corrective measures:</p> <p>Director of Nursing or designee will complete audits to ensure that staff are communicating to residents in a professional and respectful manner and are utilizing all resources available, language services if appropriate, to communicate with residents in a manner in which the resident has the greatest likelihood to understand. The sample census for each review will be 10% of facility population divided among the different shift. The audits will occur on the following schedule: daily until 100% compliance is noted for five consecutive days, then three times a week until 100% compliance is noted for three consecutive weeks, then monthly until 100% compliance is noted for three consecutive months. Audit results will be forwarded to the facility QAPI committee. (Exhibit 2)</p>		

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F 550	<p>Continued From page 5</p> <p>conversational volume in Spanish to R29.</p> <p>1:38 PM - R29 ambulated with a walker to the computer kiosk at the nurses station and began speaking Spanish in a typical volume for conversation and was making eye contact with E14 (CNA) who was standing up documenting on the computer. E15 (RN) and E17 (LPN) were seated at the same nurses station.</p> <p>1:40 PM - R29 continued speaking Spanish to E14 (CNA) who then responded in a volume greater than typical for conversation, while leaning into R29's face, "I don't know what you're saying", in English. E15 (RN) then stated, "Yeah poquito", "speak slower" in English. Poquito means small or little in Spanish, not slower. R29 responded in Spanish, looking back and forth at E14 and E15.</p> <p>1:41 PM - E14 (CNA) was still standing at the computer kiosk at the nursing station and stated in English in a volume greater than typical for conversation, "Did you use the bathroom? I don't know what you are saying." R29 continued to respond to E14 in Spanish, and R29's eye's appeared shiny, as if tearful, R29's volume began to elevate slightly above typical for conversation and her tone was seemingly distraught and plaintive.</p> <p>1:42 PM - E14 (CNA) laughed loudly in R29's face, then stated loudly, "No comprende" (I don't understand). R29 began to turn around towards the hall and E14 (CNA) laughed again and said to E15 (RN) and E17 (LPN) "Oh she getting ready to get mad now" then began to laugh some more.</p> <p>1:45 PM - R29 returned to the nurses station and</p>	F 550			

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F 550	Continued From page 6 began speaking Spanish to E14 (CNA) who responded in English, in a much greater volume than typical for normal conversation "No ma'am, no ma'am" four times, while shaking her head back and forth, while standing less than an arms length from R29 and having her head bent towards R29. On 10/14/19 E14 (CNA) was observed speaking in a language that was not fluent to R29, in a volume that was louder than typical for normal conversation, shouting, and a tone that was condescending as evidenced by laughing intermittently and speaking in English, while R29 attempted to communicate with E14 in Spanish. Additionally, E14 asked R29 if there was a need to use the bathroom, failing to ensure R29's privacy by asking this question at the nurses station in front of other staff, residents and visitors. These findings were reviewed during the exit conference on 10/21/19, beginning at 2:50 PM, with E2 (DON), E3 (ADON) and E1 (NHA, via phone).	F 550			
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R41) out of 40 residents sampled for investigations, the facility failed to ensure the accuracy of MDS (Minimum Data Set) assessments. Findings include:	F 641	Corrective Measures for residents affected: MDS for resident R41 was corrected to reflect correct diagnosis. Identification of others with the potential to	12/16/19	

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F 641	Continued From page 7 Review of R41's clinical record revealed: 9/1/17 - R41 was admitted to the facility. 7/19/18 - Notification of Level 1.5 Preadmission Screening and Resident Review (PASARR) Quality Assurance Review by the State Mental Health Authority determined that R41 had "a documented serious mental illness ...[R41] has mental health diagnoses of bipolar disorder, generalized anxiety disorder, dementia and schizoaffective disorder..." 8/21/19 - An annual MDS assessment incorrectly documented that R41 was not considered by the State PASARR process to have a serious mental illness and/or intellectual disability or related condition. The MDS assessment documented that R41 had an active diagnosis of schizophrenia which is considered by the state PASARR to be a serious mental illness. 10/21/19 9:12 AM - During an interview with E12 (RNAC), the above MDS coding error was reviewed.. These findings were reviewed during the exit conference on 10/21/19, beginning at 2:50 PM, with E2 (DON), E3 (ADON) and E1 (NHA, via phone).	F 641	be affected: All facility residents have the potential to be affected. Clinical Reimbursement Nurse will complete 100% audit of all level 1.5 and level 2 PASSR resident's with a diagnosis of mental illness to ensure that MDS section is coding correctly. (Exhibit 3) Measures to prevent recurrence: MDS Coordinator and Managers are to be educated on importance of ensuring that mental illness diagnoses are coded accurately on the MDS. (Exhibit 4) Monitoring of corrective measures: Director of Nursing or designee will complete audits to ensure that resident's with a diagnosis of mental illness are coded on MDS section is correctly. The audits will occur on the following schedule: daily until 100% compliance is noted for five consecutive days, then three times a week until 100% compliance is noted for three consecutive weeks, then monthly until 100% compliance is noted for three consecutive months. Audit results will be forwarded to the facility QAPI committee. (Exhibit 4)		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C	F 644		12/16/19	

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F 644	<p>Continued From page 8</p> <p>of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes:</p> <p>§483.20(e)(1) Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care.</p> <p>§483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, it was determined that the facility failed to have a Preadmission Screening and Resident Review (PASARR) on admission from the state authority for one (R66) out of one sampled residents. Findings include:</p> <p>Review of R66's clinical record revealed the following:</p> <p>9/19/18 - R66 was admitted to the facility.</p> <p>The facility failed to have a PASARR review from the State authority for R66 prior to admission.</p> <p>10/16/19 at 11:35 AM - An email contact with the State PASARR unit revealed that no screening was completed for R66.</p> <p>During an interview on 10/16/19 at 11:51 AM, E7 (Social Worker) stated that the facility does not have a PASARR level II for R66. E7 (SW) will</p>	F 644	<p>Corrective Measures for residents affected: Division of Medicaid and Medical Assistance – Pre -Admission Screening & Resident Review Unit is in the process of reviewing the information for R66.</p> <p>Identification of others with the potential to be affected: All facility residents have the potential to be affected. Facility Social Worker or designee will complete an audit of facility residents to ensure that facility has a PASARR on file for all residents with goal of all residents having a PASARR. (Exhibit 3)</p> <p>Measures to prevent recurrence: Managers to be educated on the need to have a PASARR on all potential admissions prior to admission. (Exhibit 4) PASARR document will be incorporated</p>		

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F 644	Continued From page 9 initiate the process for a PASARR today. These findings were reviewed during the exit conference on 10/21/19, beginning at 2:50 PM, with E2 (DON), E3 (ADON) and E1 (NHA, via phone).	F 644	into the IDT review of all new admits to ensure that PASARR is obtained and that a plan of care that meets need of resident is established. Monitoring of corrective measures: Business Office Manager or designee will complete audits to ensure that PASARR are obtained on all new admissions prior to admission. The audits will occur on the following schedule: daily until 100% compliance is noted for five consecutive days, then three times a week until 100% compliance is noted for three consecutive weeks, then monthly until 100% compliance is noted for three consecutive months. Audit results will be forwarded to the facility QAPI committee. (Exhibit 3)		
F 646 SS=D	MD/ID Significant Change Notification CFR(s): 483.20(k)(4) §483.20(k)(4) A nursing facility must notify the state mental health authority or state intellectual disability authority, as applicable, promptly after a significant change in the mental or physical condition of a resident who has mental illness or intellectual disability for resident review. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for one (R66) out of one sampled resident for Preadmission Screening and Resident Review (PASARR) the facility failed to notify the state mental health authority after a significant change in R66's mental condition. Findings include: The following was reviewed in R66's clinical	F 646	Corrective Measures for residents affected: Division of Medicaid and Medical Assistance – Pre -Admission Screening & Resident Review Unit is in the process of reviewing the information for R66. Identification of others with the potential to be affected:	12/16/19	

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F 646	<p>Continued From page 10 record:</p> <p>9/18/18 - R66 was admitted to the facility.</p> <p>9/18/19 - R66's record had a level I PASARR screening that included a diagnosis of depression and R66 was not receiving medications.</p> <p>9/25/19 - The admission MDS assessment was coded "no" to the question, "Is the resident currently considered by the State level II PASARR process to have serious mental illness and/or intellectual disability, mental retardation in federal regulation or a related condition?"</p> <p>According to physician orders in December 2018 R66 was prescribed Zyprexa for depression and Risperdal for psychosis.</p> <p>12/13/18 - The quarterly MDS assessment included a diagnosis of psychotic disorder and R66 received both antipsychotic and antianxiety medications.</p> <p>A new PASARR was not completed with the new diagnosis of psychosis.</p> <p>According to a review of the psychiatric notes, R66 had diagnoses of the following:</p> <p>12/28/18 - Major depressive disorder and anxiety disorder.</p> <p>1/11/19 - Major depressive disorder, anxiety disorder and adjustment disorder.</p> <p>1/17/19 - Major depressive disorder, anxiety disorder and adjustment disorder.</p>	F 646	<p>All facility residents have the potential to be affected. Facility Social Worker and MDS Coordinator will complete an audit of facility residents to ensure that residents with a significant change in mental condition had/will have a new PASARR review. (Exhibit 3)</p> <p>Measures to prevent recurrence: Morning Report IDT to review of the following information to determine if PASARR unit needs to be notified for an additional review: new diagnosis, new/enhanced behaviors, addition of antipsychotic and antianxiety medication, and Psych Consultant notes. Managers to be educated on the need to initiate a new PASARR on all residents that have a significant change in their mental condition. (Exhibit 4)</p> <p>Monitoring of corrective measures: Director of Nursing or designee will complete audits to ensure that new PASARRs are obtained on all residents that have a significant change. The audits will occur on the following schedule: daily until 100% compliance is noted for five consecutive days, then three times a week until 100% compliance is noted for three consecutive weeks, then monthly until 100% compliance is noted for three consecutive months. Audit results will be forwarded to the facility QAPI committee. (Exhibit 3)</p>		

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

PRINTED: 12/23/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085041	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/21/2019
NAME OF PROVIDER OR SUPPLIER DELMAR NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 101 E. DELAWARE AVENUE DELMAR, DE 19940		
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F 646	Continued From page 11 1/17/19 - Increase the Risperdal due to psychosis. 1/25/19 - Major depressive disorder, anxiety disorder and adjustment disorder. 2/1/19 - "Bipolar mood disorder, Anxiety disorder, adjustment disorder, Delusional disorder, Psychosis follow up on the recent med change on 1/7/19. Risperdal increased to target aggression and psychosis better." 3/15/19 - The quarterly MDS assessment included diagnoses of depression and psychotic disorder and R24 received both antipsychotic and antianxiety medications. A new PASARR was not completed with the new diagnoses. 10/16/19 at 11:35 - An email contact with the State PASARR unit revealed that no screening was completed for R66. During an interview on 10/16/19 at 11:51 AM, E7 (SW) stated that the facility does not have a PASARR level II for R66. E7 will initiate the process for a PASARR today. These findings were reviewed during the exit conference on 10/21/19, beginning at 2:50 PM, with E2 (DON), E3 (ADON) and E1 (NHA, via phone).	F 646			
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning	F 655		12/16/19	

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

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F 655	<p>Continued From page 12</p> <p>§483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must-</p> <p>(i) Be developed within 48 hours of a resident's admission.</p> <p>(ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to-</p> <p>(A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable.</p> <p>§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-</p> <p>(i) Is developed within 48 hours of the resident's admission.</p> <p>(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).</p> <p>§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:</p> <p>(i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.</p>	F 655			

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

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OMB NO. 0938-0391

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F 655	<p>Continued From page 13</p> <p>(iv) Any updated information based on the details of the comprehensive care plan, as necessary. 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 residents and/or their representative were provided a written summary of the baseline care plan including initial goals, services, treatments, resident's medications and dietary instructions for one (R234) out of two newly admitted residents sampled for baseline care plan review. Findings include:</p> <p>Record review for R234 revealed:</p> <p>9/17/19 - R234 was admitted to the facility.</p> <p>9/17/19 - A baseline care plan was initiated for R234, however, R234's clinical record lacked evidence that the baseline plan of care or a summary was provided to R234 or his representative.</p> <p>10/14/19 12:13 PM - During an interview, both R234 and his representative did not remember receiving a written summary of the baseline care plan or the initial goals, services, treatments, resident's medications or dietary instructions.</p> <p>10/14/19 10:00 AM - During an interview, E2 (DON) confirmed there was no evidence that the baseline care plan was provided to R234 or his representative. The document was not signed by facility staff or R234's representative and there was no progress note written by staff.</p> <p>These findings were reviewed during the exit conference on 10/21/19, beginning at 2:50 PM,</p>	F 655	<p>Corrective Measures for residents affected: Baseline Care Plan for R234 was sent to resident responsible party.</p> <p>Identification of others with the potential to be affected: All facility residents have the potential to be affected. Audit of current short term residents will be conducted to ensure that resident/responsible party provided Baseline Care Plan. (Exhibit # 5)</p> <p>Measures to prevent recurrence: Morning Report IDT to develop and review the Baseline Care Plan. Managers and Licensed Staff to be educated on the need to initiate Baseline Care Plan and review the Baseline Care Plan with resident / responsible party. Staff to document their review and provide a copy of Baseline Care plan to resident / responsible party. (Exhibit 6)</p> <p>Monitoring of corrective measures: Administrator or designee will complete audits to ensure that Baseline Care Plans are completed in 48 hours of admission and reviewed with resident / responsible party. The audits will occur on the following schedule: daily until 100% compliance is noted for five consecutive days, then three times a week until 100% compliance is noted for three consecutive weeks, then monthly until 100%</p>		

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

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OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER DELMAR NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 101 E. DELAWARE AVENUE DELMAR, DE 19940		
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F 655	Continued From page 14 with E2 (DON), E3 (ADON) and E1 (NHA, via phone).	F 655	compliance is noted for three consecutive months. Audit results will be forwarded to the facility QAPI committee. (Exhibit 5)	12/16/19	
F 656 SS=D	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 future discharge. Facilities must document	F 656			

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

PRINTED: 12/23/2019
FORM APPROVED
OMB NO. 0938-0391

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F 656	<p>Continued From page 15</p> <p>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 record review and interview, it was determined that for one (R29) out of one sampled resident for communication the facility failed to develop and implement a care plan to reflect the accurate intervention. Findings include:</p> <p>Review of R29's clinical record revealed:</p> <p>5/15/19 - A care plan for alteration in communication related to the problem of making self understood , Spanish is primary language was initiated with the goal to make needs known through the next review as evidenced by R29 making needs known. Interventions included: allow adequate time for comprehension, provide adequate time for resident to initiate or respond to communication from others, use short direct phrases, evaluate any acute or transitory conditions resulting in decreased hearing, and monitor for diseases/conditions and medications which could potentially affect communication if indicated.</p> <p>5/17/19 11:18 AM - E7 (SW) documented "patient is also able to use a communication board for needs in Spanish."</p> <p>5/21/19 - An admission MDS assessment documented R29's ability to make self</p>	F 656	<p>Corrective Measures for residents affected:</p> <p>Care Plans for R29 were updated to reflect all interventions to include Communication Book.</p> <p>Identification of others with the potential to be affected:</p> <p>All facility residents have the potential to be affected. Director of Nursing or designee will complete an audit of all residents that have communication care plans / needs to ensure that all interventions are accurate, appropriate , and listed. (Exhibit 7)</p> <p>Measures to prevent recurrence:</p> <p>Managers, Licensed Staff, and Rehab staff to be educated on the need to ensure that resident is evaluated for communication needs with a comprehensive development of a care plan that accurately reflects all interventions. (Exhibit 8)</p> <p>Monitoring of corrective measures:</p> <p>Director of Nursing or designee will complete audits to ensure that the resident's communication needs are</p>		

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

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F 656	Continued From page 16 understood and ability to understand others as a "2", sometimes understood-ability is limited to making concrete request and sometimes understands and responds adequately to simple, direct communication only. 8/14/19 - A quarterly MDS assessment documented R29's ability to make self understood and ability to understand others as a "2" as above. 10/14/19 - 10/17/19 - Daily observation's of R29's room revealed the absence of a communication board until after 12:00 PM on 10/17/19. 10/17/19 3:38 PM - E12 (RN) came to the surveyor and stated, "We have these communication boards here at the desk and also in R29's room." During an interview on 10/17/19 at 3:56 PM, E11 (Activity Director) confirmed replacing R29's communication board "sometime this afternoon." Review of R29's care plan for communication revealed interventions did not include the use of a communication board. These findings were reviewed during the exit conference on 10/21/19, beginning at 2:50 PM, with E2 (DON), E3 (ADON) and E1 (NHA, via phone).	F 656	evaluated with a comprehensive development of a care plan that accurately reflects all interventions. The sample census for each review will be 10% of facility population. The audits will occur on the following schedule: daily until 100% compliance is noted for five consecutive days, then three times a week until 100% compliance is noted for three consecutive weeks, then monthly until 100% compliance is noted for three consecutive months. Audit results will be forwarded to the facility QAPI committee. (Exhibit 7)		
F 657 SS=E	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-	F 657		12/16/19	

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

PRINTED: 12/23/2019
FORM APPROVED
OMB NO. 0938-0391

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F 657	<p>Continued From page 17</p> <p>(i) Developed within 7 days after completion of the comprehensive assessment.</p> <p>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--</p> <p>(A) The attending physician.</p> <p>(B) A registered nurse with responsibility for the resident.</p> <p>(C) A nurse aide with responsibility for the 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 for seven (R4, R17, R33, R34, R40, R42 and R51) out of 40 residents sampled for investigations, the facility failed to ensure that care plans were developed by all required members of the IDT (Interdisciplinary Team). Findings include:</p> <p>1. Review of R51's clinical record revealed:</p> <p>6/3/19 - A quarterly MDS assessment was completed with an observation end date of 6/3/19.</p>	F 657	<p>Corrective Measures for residents affected:</p> <p>Due to the nature of the issue, the facility cannot correct past records or practices.</p> <p>Identification of others with the potential to be affected:</p> <p>All facility residents have the potential to be affected.</p> <p>Measures to prevent recurrence:</p> <p>Managers, Licensed, Dietary, Recreation, Rehab, and Nurse Aides to be educated</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 657	<p>Continued From page 18</p> <p>6/7/19 - The page entitled "Interdisciplinary Care Plan Meeting Attendance" revealed that no dietary staff signed R51's care plan, indicating they did not participate in the IDT meeting.</p> <p>9/2/19 - A quarterly MDS assessment was completed with an observation end date of 9/2/19.</p> <p>9/3/19 - The page entitled "Interdisciplinary Care Plan Meeting Attendance" revealed that no dietary staff signed R51's care plan, indicating they did not participate in the IDT meeting.</p> <p>2. Review of R34's clinical record revealed:</p> <p>8/16/19 - The page entitled "Interdisciplinary Care Plan Meeting Attendance" revealed that no CNA signed R34's care plan, indicating they did not participate in the IDT meeting and, further, that the care plan meeting occurred prior to the completion of the MDS.</p> <p>8/19/19 - A quarterly MDS assessment was completed with an observation end date of 8/19/19.</p> <p>3. Review of R4's clinical record revealed:</p> <p>7/12/19 - The page entitled "Interdisciplinary Care Plan Meeting Attendance" revealed that no dietary staff signed R4's care plan, indicating they did not participate in the IDT meeting and, further, that the care plan meeting occurred prior to the completion of the MDS.</p> <p>7/14/19 - A quarterly MDS assessment was completed with an observation end date of</p>	F 657	<p>on the need for all disciplines to collaborate in the initial development and ongoing review of resident care plans which includes participation in Care Plan Meetings that are held throughout the year. Education will include the need to schedule Care Plan Meetings after the completion of the MDS. (Exhibit 10)</p> <p>Monitoring of corrective measures: Administrator or designee will complete audits to ensure that Care Plan Meetings are held after the completion of the MDS and that all disciplines participate in the Care Plan Meetings. The audits will occur on the following schedule: daily until 100% compliance is noted for five consecutive days, then three times a week until 100% compliance is noted for three consecutive weeks, then monthly until 100% compliance is noted for three consecutive months. Audit results will be forwarded to the facility QAPI committee. (Exhibit 11)</p>		

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

PRINTED: 12/23/2019
FORM APPROVED
OMB NO. 0938-0391

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F 657	<p>Continued From page 19 7/14/19.</p> <p>4. Review of R40's clinical record revealed: 8/20/19 - A quarterly MDS assessment was completed with an observation end date of 8/20/19. 8/22/19 - The page entitled "Interdisciplinary Care Plan Meeting Attendance" revealed that no dietary staff, CNA or nurse signed R40's care plan, indicating they did not participate in the IDT meeting.</p> <p>5. Review of R42's clinical record revealed: 8/22/19 - The page entitled "Interdisciplinary Care Plan Meeting Attendance" revealed that no CNA signed R42's care plan, indicating they did not participate in the IDT meeting and, further, that the care plan meeting occurred prior to the completion of the MDS. 8/23/19 - A quarterly MDS assessment was completed with an observation end date of 8/23/19.</p> <p>6. Review of R33's clinical record revealed: 5/17/19 - The page entitled "Interdisciplinary Care Plan Meeting Attendance" revealed that no dietary staff signed R33's care plan, indicating they did not participate in the IDT meeting and, further, that the care plan meeting occurred prior to the completion of the MDS. 5/19/19 - A quarterly MDS assessment was completed with an observation end date of 5/19/19.</p>	F 657			

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

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F 657	<p>Continued From page 20</p> <p>7. Review of R17's clinical record revealed:</p> <p>1/4/19 - The page entitled "Interdisciplinary Care Plan Meeting Attendance" revealed that no dietary staff or CNA signed R17's care plan, indicating they did not participate in the IDT meeting and, further, that the care plan meeting occurred prior to the completion of the MDS.</p> <p>1/22/19 - An annual MDS assessment was completed with an observation end date of 1/22/19.</p> <p>4/21/19 - A quarterly MDS assessment was completed with an observation end date of 4/21/19.</p> <p>4/24/19 - The page entitled "Interdisciplinary Care Plan Meeting Attendance" revealed that no dietary staff signed R17's care plan, indicating they did not participate in the IDT meeting.</p> <p>7/19/19 - The page entitled "Interdisciplinary Care Plan Meeting Attendance" revealed that no nurse signed R17's care plan, indicating they did not participate in the IDT meeting and, further, that the care plan meeting occurred prior to the completion of the MDS.</p> <p>7/21/19 - A Quarterly MDS assessment was completed with an observation end date of 7/21/19.</p> <p>10/18/19 11:28 AM - An interview with E7 (SW) confirmed that all attendees at the care plan meetings are documented in the Interdisciplinary Care Plan Meeting Attendance notes and lack of a signature indicated that particular discipline did</p>	F 657		

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

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FORM APPROVED
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER DELMAR NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 101 E. DELAWARE AVENUE DELMAR, DE 19940		
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F 657	Continued From page 21 not attend. E7 stated there was no documentation where any additional participants would be listed.	F 657			
F 660 SS=D	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the	F 660		12/16/19	

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

PRINTED: 12/23/2019
FORM APPROVED
OMB NO. 0938-0391

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F 660	Continued From page 22 discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or	F 660			

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

PRINTED: 12/23/2019
FORM APPROVED
OMB NO. 0938-0391

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F 660	<p>Continued From page 23</p> <p>resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, it was determined that for one (R85) out of one resident reviewed for discharge, the facility failed to involve the interdisciplinary team (IDT), specifically, a CNA responsible for R85's care in the discharge planning process. Findings include:</p> <p>Review of R85's clinical record revealed:</p> <p>7/20/19 - R85 was admitted to the facility for short term placement.</p> <p>7/22/19 - A discharge care plan was initiated for R85 with the goal to discharge home after therapy. Interventions included: R85 will be evaluated by team quarterly to be evaluated for appropriate level of care and potential for discharge, involve family in care planning and discharge planning, and enlist family support as needed.</p> <p>7/23/19 - A care plan meeting to discuss a discharge plan for R85 was held, and included the attendance of the following members of the IDT: Nursing, PT/OT, SW, Dietary, Activities, Administration, and MD. There was no evidence on the sign in attendance sheet that a CNA responsible for R85's care was in attendance.</p> <p>7/27/19 - An admission MDS assessment documented that R85 participated in her discharge in a plan already occurring for the</p>	F 660	<p>Corrective Measures for residents affected:</p> <p>Due to the nature of the issue, the facility cannot correct past records or practices.</p> <p>Identification of others with the potential to be affected:</p> <p>All facility residents have the potential to be affected.</p> <p>Measures to prevent recurrence:</p> <p>Managers, Licensed, Dietary, Recreation, Rehab and Nurse Aides to be educated on the need for all disciplines to collaborate in the initial development and ongoing review of resident care plans, which includes participation in Discharge Care Plan Meetings. (Exhibit 10)</p> <p>Monitoring of corrective measures:</p> <p>Administrator or designee will complete audits to ensure that all disciplines participate in Discharge Care Plan Meetings. The audits will occur on the following schedule: daily until 100% compliance is noted for five consecutive days, then three times a week until 100% compliance is noted for three consecutive weeks, then monthly until 100% compliance is noted for three consecutive months. Audit results will be forwarded to the facility QAPI committee. (Exhibit 11)</p>	

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

PRINTED: 12/23/2019
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OMB NO. 0938-0391

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F 660	Continued From page 24 resident to return to the community. During an interview on 10/15/19 at 2:18 PM with E7 (SW), it was confirmed that a CNA responsible for R85's care was not included in the IDT that discussed discharge planning for R85. These findings were reviewed during the exit conference on 10/21/19, beginning at 2:50 PM, with E2 (DON), E3 (ADON) and E1 (NHA, via phone).	F 660			
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care,	F 676		12/16/19	

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

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FORM APPROVED
OMB NO. 0938-0391

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F 676	<p>Continued From page 25</p> <p>§483.24(b)(2) Mobility-transfer and ambulation, including walking,</p> <p>§483.24(b)(3) Elimination-toileting,</p> <p>§483.24(b)(4) Dining-eating, including meals and snacks,</p> <p>§483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of facility documentation, it was determined that for one (R29) out of one resident sampled for communication, the facility failed to provide the necessary care and services to ensure effective communication between the staff and R29, who did not fluently speak English. Findings include:</p> <p>Review of R29's clinical record included the following:</p> <p>5/14/19 - R29 was admitted to the facility.</p> <p>5/15/19 - A care plan was initiated for alteration in communication related to the problem of making self understood. Spanish is the primary language. The care plan goal was to make R29's needs known through the next review as evidenced by R29 making her needs known. Interventions included: allow adequate time for comprehension, provide adequate time for resident to initiate or respond to communication from others, use short direct phrases, evaluate any acute or transitory conditions resulting in decreased hearing, and monitor for</p>	F 676	<p>Corrective Measures for residents affected: Care Plans for R29 were updated to reflect all interventions to include Communication Book and access to language line. Communication & Languages book were placed on all Nursing Units.</p> <p>Identification of others with the potential to be affected: All facility residents have the potential to be affected. Director of Nursing or designee will complete an audit of facility residents to ensure that care plan reflect accurate and appropriate interventions related to a residents ability to communication, which includes Communication Books and Language Services. (Exhibit 7)</p> <p>Measures to prevent recurrence: Managers, Licensed Staff, and Rehab staff to be educated on the need to ensure that resident is evaluated for</p>	

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

PRINTED: 12/23/2019
FORM APPROVED
OMB NO. 0938-0391

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F 676	<p>Continued From page 26</p> <p>diseases/conditions and medications which could potentially affect communication if indicated. R29's care plan for communication interventions did not include the use of a communication board nor the use of a language line for access to an interpreter.</p> <p>5/17/19 11:18 AM - E7 (SW) documented in R29's clinical record, "patient is also able to use a communication board for needs in Spanish."</p> <p>5/21/19 - An admission MDS assessment documented R29's ability to make self understood and ability to understand others as a "2", sometimes understood-ability is limited to making concrete request and sometimes understands, and responds adequately to simple, direct communication only.</p> <p>8/14/19 - A quarterly MDS assessment documented R29's ability to make self understood and ability to understand others as a "2" as above.</p> <p>8/21/19 - E24 (MD) documented R29 as "alert with clear speech, mix of Spanish and English follows some, confused."</p> <p>10/14/19 - During random observations from 12:45 PM through 1:54 PM the following interactions occurred:</p> <p>12:45 PM to 1:30 PM - R29 had visitors in and all were observed sitting in the unit seating area eating strawberries and speaking in a typical conversational volume in Spanish to R29.</p> <p>1:38 PM - R29 ambulated with a walker to the computer kiosk at the nurses station and began</p>	F 676	<p>communication needs with a comprehensive development of a care plan that accurately reflects all interventions, which includes Communication Books and Language Services. Staff education will include how to utilize Communication Book and access Language Services. (Exhibit 8)</p> <p>Monitoring of corrective measures: Director of Nursing or designee will complete audits to ensure that the resident's communication needs are evaluated with a comprehensive development of a care plan that accurately reflects all interventions including Communication Book and Language Services. The audits will occur on the following schedule: daily until 100% compliance is noted for five consecutive days, then three times a week until 100% compliance is noted for three consecutive weeks, then monthly until 100% compliance is noted for three consecutive months. Audit results will be forwarded to the facility QAPI committee. (Exhibit 7)</p>		

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F 676	<p>Continued From page 27</p> <p>speaking Spanish in a typical volume for conversation and was making eye contact with E14 (CNA) who was standing up documenting on the computer. E15 (RN) and E17 (LPN) were seated at the same nurses station.</p> <p>1:40 PM - R29 continued speaking Spanish to E14 (CNA) who then responded in a volume greater than typical for conversation, while leaning into R29's face, "I don't know what you're saying", in English. E15 (RN) then stated, "Yeah poquito", "Speak slower" in English. Poquito means small or little in Spanish, not slower. R29 responded in Spanish, looking back and forth at E14 and E15.</p> <p>1:41 PM - E14 (CNA) was still standing at the computer kiosk at the nursing station and stated in English in a volume greater than typical for conversation, "Did you use the bathroom? I don't know what you are saying." R29 continued to respond to E14 in Spanish, and R29's eye's appeared shiny, as if tearful, R29's volume began to elevate slightly above typical for conversation and her tone was seemingly distraught and plaintive.</p> <p>1:42 PM - E14 (CNA) laughed loudly in R29's face, then stated loudly, "No comprende" (I don't understand). R29 began to turn around towards the hall and E14 (CNA) laughed again and said to E15 (RN) and E17 (LPN), "Oh she getting ready to get mad now" then began to laugh some more.</p> <p>1:45 PM - R29 returned to the nurses station and began speaking Spanish to E14 (CNA) who responded in English, in much greater volume than typical for normal conversation, "No ma'am, no ma'am" four times, while shaking her head</p>	F 676		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 676	<p>Continued From page 28</p> <p>back and forth, and standing less than an arms length from R29 with her head bent towards R29.</p> <p>1:53 PM - R29 repeatedly said "No comida." E15 (RN) repeated in English "No food."</p> <p>1:54 PM - E15 (RN) stated in a higher volume than typical for conversation, "Juice? Yogurt? Your son left you food?" R29 did not respond. E10 (CNA) extended yogurt to R29, who stated, "No," followed by continued sentences in Spanish. E10 then turned to E15 and stated, "I am trying to see what R29 wants, but I don't know", E15 then stated three times to R29 "No habla espanol, que poquito, in Ingles" [I don't speak Spanish, what little/small in English]. R29 continued to respond in Spanish and E15 responded, "Un poquito in Ingles" [a little/small in English] then laughed and turned away from R29.</p> <p>During an interview on 10/14/19 at 2:04 PM, E10 (CNA) was asked whether any staff was bilingual and spoke Spanish. E10 stated, "No, but [R29] can speak enough [English] for us to understand and then breaks it down with hand gestures."</p> <p>10/14/19 - 10/17/19- Daily observations of R29's room revealed the absence of a communication board until after 12:00 PM on 10/17/19.</p> <p>10/15/19 - A PT evaluation and plan of treatment documented R29 "speaks little English but is able to follow a combination of verbal visual, and tactile clues."</p> <p>10/16/19 11:16 AM - E26 (housekeeper) greeted R29 in Spanish stating "Hola." R29 responded in Spanish, E26 then shook her head sideways left to right, smiled and walked away while R29 was</p>	F 676		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 676	<p>Continued From page 29 still speaking.</p> <p>During an interview on 10/17/19 at 12:07 PM with E12 (RNAC), when asked how staff communicates with R29, and how E12 communicates with R29 during assessment periods, E12 stated that R29 "Can speak some English and Spanish according to family, but with the Alzheimers is speaking more Spanish. R29 makes needs known by pointing and R29 can understand gestures. We can communicate with her by doing that as well."</p> <p>10/17/19 3:38 PM - E12 (RNAC) came up to the surveyor and stated, "We have these communication boards [a laminated board with pictures and faces and corresponding words in both English and Spanish] here at the desk and also in R29's room." During the previous interview with E12 at 12:07 PM, there was no mention of use of a communication board by staff to communicate with R29.</p> <p>10/17/19 3:40 PM - E13 (RN) accompanied the surveyor to R29's room and pointed out a communication board taped to the outer door of R29s closet, E13 then accompanied the surveyor to the nurses station and provided the surveyor with a copy of the Spanish/English communication board that was now placed in R29's room.</p> <p>During an interview on 10/17/19 at 3:41 PM with E16 (LPN), the surveyor presented E16 with a copy of the communication board and asked where they were typically kept. E16 confirmed having no experience using the board and had not seen the board. E16 stated, "I don't know anything about it, or where it's kept, but I can find</p>	F 676			

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

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F 676	<p>Continued From page 30 out for you."</p> <p>During an interview on 10/17/19 at 3:43 PM with E5 (RN) and unit manager for R29's unit, it was reported that in addition to the communication board there was a language line binder that detailed information for access to an interpreter available at every nurses station.</p> <p>10/17/19 3:45 - 3:51 PM - E13 (RN) and E12 (RNAC) were requested by the surveyor to provide the language line binder that the facility keeps at the nurses station. Both E13 and E12 searched all of the cabinets and drawers at the nurses station. Next, E13 (RN) went into the locked room adjacent to the nurses station and was able to locate the language line binder.</p> <p>During an interview on 10/17/19 at 3:54 PM, E5 (RN) reported that the language line binder with information accessing a language interpreter is for the use of all staff to communicate with R29. The binder was located in a locked room, inaccessible to all staff.</p> <p>During an interview on 10/17/19 at 3:56 PM, E11 (Activity Director) confirmed replacing R29's communication board "sometime this afternoon." When asked if E11 notified staff or R29 that the communication board was replaced for their use, E11 confirmed that neither staff, nor R29 was notified or re-educated on use of the communication board. When asked how activity staff communicates with R29, E11 stated, "Usually we are able to call family, and if R29 is upset, we can tell by body language, or we can try to get R29 to speak English." E11 then confirmed never using an interpreter nor observing any staff use of an interpreter.</p>	F 676		

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

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F 676	<p>Continued From page 31</p> <p>10/17/19 4:00 PM - R29 was observed ambulating in the hall next to E25 (CNA). R29 was speaking Spanish to E25, who responded in English "Uh huh, come along." R29 briefly stopped speaking to E25 who then began to tug R29's sleeve and then said "Come on" in English.</p> <p>During an interview on 10/18/19 at 10:26 AM with E5 (RN), it was reported that education of staff was completed on the use of the communication board and the language line book. E5 reported that the book provided to the surveyor on 10/17/19 was the outdated book and the surveyor was provided with the updated book. Review of the copy of the language line binder given to the surveyor revealed a previous communication memo and instructions dated 6/25/12.</p> <p>During an interview on 10/18/19 at 11:07 AM with E2 (DON), it was reported that the facility practice for obtaining language services changed in June of 2015 when a change of ownership occurred and that all language line binders should have been updated at that time.</p> <p>R29 was observed on 10/14/19, 10/16/19 and 10/17/19 attempting to communicate with facility staff speaking Spanish and staff repeatedly responded to R29 in English or rudimentary Spanish that may have been difficult to interpret. During observations and interview, staff did not demonstrate the use of communication tools, such as a communication board or language line for an interpreter, additionally staff were unable to submit these items to the surveyor upon request. The facility failed to provide the necessary services to meet R29's, a resident whose primary language was not English, needs related to</p>	F 676		

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085041	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/21/2019
NAME OF PROVIDER OR SUPPLIER DELMAR NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 101 E. DELAWARE AVENUE DELMAR, DE 19940		
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F 693	<p>Continued From page 33</p> <p>resident with a gastric (stomach) feeding tube, received appropriate care and services to prevent complications for one (R75) out of two residents reviewed for gastric tube feeding care and management. Findings include:</p> <p>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. Additional information regarding monitoring of feeding tubes may be found at https://www.ismp.org/tools/articles/ASPEN.pdf</p> <p>"Auscultation verification of gastric tube (feeding tube) placement solely by auscultation, 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).</p> <p>Nurses should not use the auscultatory (air bolus)...American Association of Critical-Care Nurses updates Practice Alert on feeding tube placement 4/1/16.</p> <p>The facility policy entitled Confirming Placement of Feeding Tubes (revised November 2018, MED-PASS) included: If a change in the incremental marking or tube length is observed ...observe for symptoms of elevated gastric residual volume ...observe and check the pH of aspirate ...If the above suggest improper tube positioning, do not administer feeding or medication. Notify the Charge Nurse or Physician.</p>	F 693	<p>Facility policy on Gastrostomy Tube Instilling Medication was revised after a review policy with Medical Director. (Exhibit 28)</p> <p>Identification of others with the potential to be affected: All facility residents have the potential to be affected.</p> <p>Measures to prevent recurrence: Licensed Staff will be educated on the revised Gastronomy Tube Instilling Medication with a returned demonstration. (Exhibit 12)</p> <p>Monitoring of corrective measures: Director of Nursing or designee will complete audits to ensure that licensed staff are checking the placement of tubing per revised policy. The audits will occur on the following schedule: daily until 100% compliance is noted for five consecutive days, then three times a week until 100% compliance is noted for three consecutive weeks, then monthly until 100% compliance is noted for three consecutive months. Audit results will be forwarded to the facility QAPI committee. (Exhibit 13)</p>		

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

PRINTED: 12/23/2019
FORM APPROVED
OMB NO. 0938-0391

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F 693	<p>Continued From page 34</p> <p>1. Review of R75's clinical record included the following:</p> <p>5/10/15 - R75 was admitted to the facility.</p> <p>2/2/18 - A Physician's order was written for "Tube Feeding - Change Syringe Daily".</p> <p>2/2/18 - A Physician's order was written to "Check tube for correct placement and patency (open, unobstructed) prior to medication administration, starting feeding or flushing."</p> <p>9/26/18 - A care plan for tube feeding/nutritional status was added that the "Resident requires tube feeding due dysphagia [difficulty swallowing]; inadequate po [oral] intake" which included an intervention to "Check feeding tube patency / position before each feeding."</p> <p>9/20/19 10:22 PM - A nurse's note documented, "At approximately [8:00 PM], resident's PEG [feeding tube] site was assessed prior to evening med [medication] administration and it appeared to be protruding from abdomen further than normal. When attempted to flush, the tube became dislodged. [Nurse Practitioner] and RN supervisor made aware and resident was transported to [the hospital] via ambulance. Daughter was notified about this transfer as well."</p> <p>9/21/19 8:42 AM - A nurse's note documented, "Resident returned from hospital at 12:30 [AM] with Mickey (MIC-KEY) tube [type of feeding tube] in place. Flushed with no complications and feeding is restarted ..."</p> <p>10/14/19 10:10 AM - During a routine observation, R75's feeding pump was found to be</p>	F 693		

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

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FORM APPROVED
OMB NO. 0938-0391

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F 693	<p>Continued From page 35</p> <p>stained with many dried tan substances including in the mechanical mechanism that regulates the rate of infusion. In addition, the syringe and extension feeding tube were unlabeled (no date when opened or expired) in a plastic bag hanging from the bedside feeding pump pole.</p> <p>10/14/19 10:45 AM - E4 (LPN, Unit Manager) confirmed the above findings, disposed of the unlabeled supplies and cleaned the pump. E4 explained that R75 had a MIC-KEY button G (gastric) feeding tube. When asked, E4 stated that the feeding tube extension set did not ever need to be replaced, just cleaned after each use.</p> <p>10/18/19 8:30 AM - During an interview, E6 (RN), R75's regular day shift nurse, stated her understanding was that the feeding tube extension set did not ever need to be replaced, just cleaned after each use.</p> <p>10/18/19 3:15 PM - During an interview, E2 (DON) and E3 (ADON) stated they thought the guidelines for use of the MIC-KEY G Feeding Tube included that the extension set was reusable and did not need to be replaced. The Surveyor requested a copy of these guidelines.</p> <p>10/21/19 10:00 AM - E2 (DON) provided the surveyor a copy of the manufacturer's "MIC-KEY G Feeding Tube Care and Use Guide" (Halyard Health, Inc., September 2016) which included: "Wash the extension set after every feeding with warm soapy water and rinse it thoroughly. Prompt flushing and rinsing prevents the formula from drying and building up. Extension sets are disposable and should be replaced every few weeks." E2 (DON) confirmed the finding that the facility failed to replace the extension sets</p>	F 693		

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

PRINTED: 12/23/2019
FORM APPROVED
OMB NO. 0938-0391

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F 693	<p>Continued From page 36 according to the manufacturer's guidelines.</p> <p>2. 10/18/19 8:00 AM - During an observation of medication administration through a feeding tube, E6 (RN) verified placement of R75's feeding tube by instilling 30 mL of air drawn into a syringe then pushing the air through R75's tube while listening with a stethoscope over R75's abdomen.</p> <p>10/18/19 8:30 AM - During an interview, E6 (RN) stated her understanding was that the correct method to verify tube feeding placement was instilling air into the feeding tube. The surveyor informed E6 this was no longer recommended for checking placement of feeding tubes and to review the facility procedure.</p> <p>10/18/19 9:00 AM - During an interview, E4 (LPN, Unit Manager) stated his understanding was that the correct method to verify tube feeding placement was using air instilled into the feeding tube. The surveyor informed E4 this was no longer recommended for checking placement of feeding tubes and to review the facility procedure.</p> <p>These findings were reviewed during the exit conference on 10/21/19, beginning at 2:50 PM, with E2 (DON), E3 (ADON) and E1 (NHA, via phone).</p>	F 693		
F 694 SS=D	<p>Parenteral/IV Fluids CFR(s): 483.25(h)</p> <p>§ 483.25(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences.</p>	F 694		12/16/19

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

PRINTED: 12/23/2019
FORM APPROVED
OMB NO. 0938-0391

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F 694	<p>Continued From page 37</p> <p>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 ensure that care and services consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences were provided for one (R234) out of one resident investigated for intravenous (IV) therapy. Findings include:</p> <p>The facility's policy and procedure titled "Administration Set/Tubing Changes", revised April 2016 (MED-PASS, Inc.), included: "The purpose of this procedure is to provide guidelines for aseptic administration set changed in order to prevent infections associated with contaminated IV therapy equipment. 6. All tubing is labeled with start and change date and time. Any tubing that is observed not to have a label must be changed and then labeled accordingly."</p> <p>Review of R234's clinical record revealed the following:</p> <p>9/30/19 - R234 was admitted to the facility.</p> <p>9/30/19 - A Physician's admission order stated to "Infuse Vancomycin [antibiotic] by intravenous route 2 times per day".</p> <p>9/30/19 - A Physician's admission order stated to "Infuse Zosyn [antibiotic] by intravenous route every 6 hours".</p> <p>10/14/19 10:00 AM - A random observation in R234's room revealed that one bag of IV</p>	F 694	<p>Corrective Measures for residents affected: Resident R234's tubing was labeled correctly as soon as it was noted.</p> <p>Identification of others with the potential to be affected: All facility residents have the potential to be affected. Director of Nursing will complete an audit of facility residents to ensure that all tubing is labeled with start, change date and time. (Exhibit 14)</p> <p>Measures to prevent recurrence: Licensed Staff to be educated on the updated facility policy Administration Set/Tubing Changes (Ex 29 – Tag 694 PP). (Exhibit 15)</p> <p>Monitoring of corrective measures: Director of Nursing or designee will complete audits to ensure all tubing is labeled according to the facility policy. The audits will occur on the following schedule: daily until 100% compliance is noted for five consecutive days, then three times a week until 100% compliance is noted for three consecutive weeks, then monthly until 100% compliance is noted for three consecutive months. Audit results will be forwarded to the facility QAPI committee. (Exhibit 14)</p>	

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

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OMB NO. 0938-0391

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F 694	Continued From page 38 antibiotic (Vancomycin) was hanging on a bedside IV pole and the IV tubing connected to this bag was not labeled. 10/14/19 10:45 AM - E4 (LPN, Unit Manager) confirmed the unlabeled IV tubing and disposed of it. These findings were reviewed during the exit conference on 10/21/19, beginning at 2:50 PM, with E2 (DON), E3 (ADON) and E1 (NHA, via phone).	F 694		
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 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 record review and interview, it was determined that the facility failed to provide dialysis care and services to meet the needs for one (R34) out of one sampled resident for dialysis review by not fully completing the facility's portion of the communication form. Findings include: Review of R34's clinical record revealed the following: 8/30/19 to 9/4/19 - The Dialysis Communication form lacked a resident name, date, blood sugar, and dialysis access site assessment. 8/30/19, 9/4/19, 9/6/19, 9/11/19, 9/18/19, 9/20/19,	F 698	Corrective Measures for residents affected: Due to the nature of the issue, the facility cannot correct past records or practices. Identification of others with the potential to be affected: All facility residents have the potential to be affected. Measures to prevent recurrence: Licensed staff to be educated on the need to fully complete the facility's portion of the Dialysis Communication Log form for dialysis residents and follow through with	12/16/19

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

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F 698	Continued From page 39 9/27/19, 10/2/19, 10/11/19, and 10/14/19 - Facility staff did not complete the dialysis access site assessment. 9/6/19, 9/9/19, 9/11/19, 9/20/19, 9/25/19, 9/27/19, 10/9/19, and 10/11/19 - Facility staff did not document R34's blood sugar. 10/16/19 8:49 AM - An interview with E5 (Unit Manager) revealed that it was her expectation that all dialysis communication forms would be fully completed by staff. 10/18/19 8:15 AM - E5 (Unit Manager) provided documentation that staff education was conducted regarding proper completion of dialysis forms. These findings were reviewed during the exit conference on 10/21/19, beginning at 2:50 PM, with E2 (DON), E3 (ADON) and E1 (NHA, via phone).	F 698	dialysis centers to ensure returned completed Dialysis Communication Log. (Exhibit 16) Monitoring of corrective measures: Director of Nursing or designee will complete audits to ensure that facility's portion of the Dialysis Communication Log form for dialysis residents. The audits will occur on the following schedule: daily until 100% compliance is noted for five consecutive days, then three times a week until 100% compliance is noted for three consecutive weeks, then monthly until 100% compliance is noted for three consecutive months. Audit results will be forwarded to the facility QAPI committee. (Exhibit 17)		
F 725 SS=D	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).	F 725		12/16/19	

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

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	<p>Continued From page 40</p> <p>§483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:</p> <p>(i) Except when waived under paragraph (e) of this section, licensed nurses; and</p> <p>(ii) Other nursing personnel, including but not limited to nurse aides.</p> <p>§483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interviews and review of facility documentation, it was determined that for three (R40, R184, and R235) out of 26 initial pool residents interviewed, four residents who wished to remain anonymous (A1, A2, A3, and A4), and five other residents (R6, R30, R136, R137, and R138), the facility failed to provide sufficient nursing staff on a 24 hour basis to meet resident care needs. Findings include:</p> <p>1. January 2019 - October 2019 - Review of resident grievances revealed the following concerns related to staffing concerns:</p> <p>1a. 1/21/19 R137 - "1/20/19 around 2:30 AM resident was up in power chair. Resident requested to be put back to bed. Resident stated that E9 (CNA) told resident that E9 had to find another person to assist. It was over 45 minutes before E9 found a Hoyer (type of lift) and a second person to help. R137 felt punished."</p> <p>1b. 2/27/19 R136 - Resident spoke with this writer</p>		<p>Corrective Measures for residents affected:</p> <p>Due to the nature of the issue, the facility cannot correct past practices.</p> <p>Identification of others with the potential to be affected:</p> <p>All facility residents have the potential to be affected.</p> <p>Measures to prevent recurrence:</p> <p>All facility staff to be educated on Customer Service and timely response to call bell and resident requests. (Exhibit 18)</p> <p>Monitoring of corrective measures:</p> <p>Director of Nursing or designee will complete audits to gather residents input in terms of staffing as it relates to response time. Audits will be completed to determine response time to call bells. The sample census for each review will</p>	

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

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F 725	<p>Continued From page 41</p> <p>about concerns with not receiving meds. R136 stated she rang the call bell at 4:30 AM, the pain medication was delivered to the resident at 5:17 AM per electronic notes. R136 also had concerns over not seeing or understanding why she "has not gotten insulin check on time", as well.</p> <p>1c. 3/29/19 R138 - "On 3/28/19 R138 rang the call bell several times from 4:00 PM-6:00 PM. Rang the bell about 5 times in that 4:00-6:00 PM time period. No aide came five times to help. Friend of resident went to find someone each time... Long periods to wait for call bells."</p> <p>1d. 3/31/19 R6 - "Resident reported that waiting from 6:00 PM - 7:20 PM to use the restroom on 3/30/19 evening shift. R6 stated the nurse told R6 to wait until after trays were passed out."</p> <p>1e. 10/10/19 R30 - "Waited for approximately 20 minutes for assistance after ringing bell/light in hallway bathroom across from therapy room. Stated it was during 3-11 shift E8 (CNA) walked by and saw R30 asked, if R30 was ok and resident said "no" but resident said E8 just kept walking. Resident said 20 minutes was an estimate but R30 finally turned out the light because no one ever came and self- assisted to pull up the brief."</p> <p>2. During initial pool interviews, in response to being asked whether residents "Receive the care and assistance they need without having to wait a long time?" the following responses were given:</p> <p>2a. 10/14/19 10:15 AM - R184 responded, "The day shift is good but the weekend and nights act like they are not trained or don't care . If you ask them for help they act like they are annoyed to be</p>	F 725	<p>be 10% of facility population divided among the different shift. The audits will occur on the following schedule: daily until 100% compliance is noted for five consecutive days, then three times a week until 100% compliance is noted for three consecutive weeks, then monthly until 100% compliance is noted for three consecutive months. Audit results will be forwarded to the facility QAPI committee. (Exhibit 2 & 19)</p>	

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

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F 725	<p>Continued From page 42</p> <p>asked, but they do it; also waits but not specific examples."</p> <p>2b. 10/14/19 12:41 PM - R235 responded, "On average 30 minutes and also I hear other call bells go off for 30 minutes."</p> <p>2c. 10/15/19 6:50 AM - R40 responded, "I get frustrated and can't find the call bell - or I get tired of waiting... I have messed myself cause of needing to have a bowel movement and staff didn't come... "</p> <p>3. During a resident council meeting on 10/17/19 at 1:30 PM , in reference to the question "Do you get the care and assistance you need, without having to wait a long time?", the following anonymous responses were given:</p> <p>3a. A1 - "No! Sometimes it's an hour."</p> <p>3b. A2 - "For medicine 3 hours. I rang the bell no one came for 15 minutes and I needed oxygen, they need two nurses on the floor they have one nurse for 30 patients they need more help. It makes it hard living here."</p> <p>3c. A3 - " If you can't get to the bell and call out they walk right on by. 11:00 PM-7:00 PM was the worse."</p> <p>3d. A4 - "I recently have stirred up injury so when I asked to be pushed [in wheelchair] they don't understand that (my)needs change daily and your told you know how to do that."</p> <p>These findings were reviewed during the exit conference on 10/21/19, beginning at 2:50 PM, with E2 (DON), E3 (ADON) and E1 (NHA, via</p>	F 725		

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

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F 725 F 842 SS=D	Continued From page 43 phone). Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation	F 725 F 842		12/16/19

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

PRINTED: 12/23/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085041	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/21/2019
NAME OF PROVIDER OR SUPPLIER DELMAR NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 101 E. DELAWARE AVENUE DELMAR, DE 19940		
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F 842	<p>Continued From page 44</p> <p>purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.</p> <p>§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.</p> <p>§483.70(i)(4) Medical records must be retained for-</p> <p>(i) The period of time required by State law; or</p> <p>(ii) Five years from the date of discharge when there is no requirement in State law; or</p> <p>(iii) For a minor, 3 years after a resident reaches legal age under State law.</p> <p>§483.70(i)(5) The medical record must contain-</p> <p>(i) Sufficient information to identify the resident;</p> <p>(ii) A record of the resident's assessments;</p> <p>(iii) The comprehensive plan of care and services provided;</p> <p>(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;</p> <p>(v) Physician's, nurse's, and other licensed professional's progress notes; and</p> <p>(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, it was determined that for one (R4) out of 40 residents sampled for investigations, the facility failed to ensure that respiratory orders were accurately documented. Findings include:</p> <p>10/17/19 - untimed - A review of R4's orders revealed the following:</p>	F 842	<p>Corrective Measures for residents affected: Resident R4's respiratory order was corrected as soon as it was noted.</p> <p>Identification of others with the potential to be affected: All facility residents have the potential to</p>		

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

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OMB NO. 0938-0391

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F 842	<p>Continued From page 45</p> <p>O2 (oxygen) tubing, O2 bottle and Neb (nebulizer - a device for producing a fine spray of liquid, used for inhaling a medicinal drug) kit changed and dated every Thursday 7p-7a; and Change oxygen tubing and nebulizer tubing every week on Wednesday's 7p-7a ...</p> <p>10/17/19 at approximately 8:40 AM - An interview with E5 (unit manager) revealed that it was the facility's policy to change oxygen equipment every week and this was done on Thursday on the evening shift beginning at 7:00 PM. The surveyor pointed out that R4 had two orders, as outlined above. E5 stated, "I will change this now".</p> <p>These findings were reviewed during the exit conference on 10/21/19, beginning at 2:50 PM, with E2 (DON), E3 (ADON) and E1 (NHA, via phone).</p>	F 842	<p>be affected. Director of Nursing or designee will complete an audit of facility residents with respiratory orders to ensure that orders are adequately documented. (Exhibit 20)</p> <p>Measures to prevent recurrence: All licensed staff to be educated on the need ensure that orders are documented in a timely and accurate manner. (Exhibit 21)</p> <p>Monitoring of corrective measures: Director of Nursing or designee will complete audit to ensure the accuracy of documentation of orders. The audits will occur on the following schedule: daily until 100% compliance is noted for five consecutive days, then three times a week until 100% compliance is noted for three consecutive weeks, then monthly until 100% compliance is noted for three consecutive months. Audit results will be forwarded to the facility QAPI committee. (Exhibit 20)</p>	
F 880 SS=E	<p>Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)</p> <p>§483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.</p> <p>§483.80(a) Infection prevention and control program.</p>	F 880		12/16/19

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

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F 880	<p>Continued From page 46</p> <p>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:</p> <p>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv) When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and</p>	F 880			

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F 880	<p>Continued From page 47</p> <p>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to conduct an annual review of their infection prevention and control policies. Findings include:</p> <p>Review of infection prevention and control policies revealed:</p> <ul style="list-style-type: none"> - A facility policy titled Antibiotic Stewardship, Review of Surveillance of Antibiotic Use/Outcomes Health Care, initiated November 2017, was last reviewed and revised in April 2018. There was no evidence of a review date over the past year. - A facility policy titled Antibiotic Stewardship, initiated November 2017, was last reviewed and revised in April 2018. There was no evidence of a review date over the past year. - A facility policy titled Antibiotic Stewardship - Staff and Clinical Training and Roles, initiated 	F 880	<p>Corrective Measures for residents affected: Delmar Infection Control policies have been reviewed and updated, if needed.</p> <p>Measures to prevent recurrence: Managers to be educated on the need to ensure that policies and procedures are reviewed annually or according to stated regulatory requirements. (Exhibit 22)</p> <p>Monitoring of corrective measures: Administrator or designee will complete audit to ensure that Infection Control policy have been reviewed within the last year. The audits will occur on the following schedule: daily until 100% compliance is noted for five consecutive days, then three times a week until 100% compliance is noted for three consecutive weeks, then monthly until 100% compliance is noted for three consecutive</p>	

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

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F 880	Continued From page 48 November 2017, was last reviewed and revised in April 2018. There was no evidence of a review date over the past year. E3 (ADON) confirmed the above findings on 10/22/19 at 10:09 AM. These findings were reviewed during the exit conference on 10/21/19, beginning at 2:50 PM, with E2 (DON), E3 (ADON) and E1 (NHA, via phone).	F 880	months. Audit results will be forwarded to the facility QAPI committee. (Exhibit 23)		
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	F 883		12/16/19	

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

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F 883	<p>Continued From page 49</p> <p>immunization due to medical contraindications or refusal.</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 for two (R49 and R58) out of six sampled residents, the facility failed to maintain medical records including documentaion of the resident being offered the pneumococcal immunization. Findings include:</p> <p>A facility policy titled Infection Control Program, originated in April 2018, last updated August</p>	F 883	<p>Corrective Measures for residents affected:</p> <p>Resident R49 received pneumococcal vaccination on 10/22/19. R58 husband is in the process of reviewing consent form for vaccination administration.</p> <p>Identification of others with the potential to be affected:</p>		

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F 883	Continued From page 50 2019, section Policy Interpretation and Implementation, revealed, "Newly admitted residents will be asked to provide an immunization history for Influenza and Pneumonia (pneumococcal) and any needed immunizations (provided consent is given) will be provided by the facility." Review of the completed Tuberculosis Testing/Infection Control survey form revealed: 1. R49's Pneumonia immunization date was not provided. 2. R58's Pneumonia immunization date was not provided. During an interview on 10/18/19 at 11:30 AM, E2 (ADON) confirmed that there was no evidence that R49 and R58 were asked about their pneumococcal immunization history, nor that they were offered or received a pneumococcal vaccine at the facility. These findings were reviewed during the exit conference on 10/21/19, beginning at 2:50 PM, with E2 (DON), E3 (ADON) and E1 (NHA, via phone).	F 883	All facility residents have the potential to be affected. Assistant Director of Nursing or designee will complete an audit of facility residents to ensure that medical records include documentation of the resident being offered the pneumococcal immunization. (Exhibit 24) Measures to prevent recurrence: Facility Fact Sheets and Consent forms to be added to the paperwork that is signed by resident / responsible part upon admission. All licensed staff to be educated on the need to obtain and document in the medical record resident's vaccination history and facility's role in offering and tracking vaccinations. (Exhibit 25) Monitoring of corrective measures: Director of Nursing or designee will complete audit to ensure the gathering of historical data from residents on vaccinations and the tracking and offering of vaccinations. The audits will occur on the following schedule: daily until 100% compliance is noted for five consecutive days, then three times a week until 100% compliance is noted for three consecutive weeks, then monthly until 100% compliance is noted for three consecutive months. Audit results will be forwarded to the facility QAPI committee. (Exhibit 24)		
F 943 SS=D	Abuse, Neglect, and Exploitation Training CFR(s): 483.95(c)(1)-(3) §483.95(c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect,	F 943		12/16/19	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 943	<p>Continued From page 51 and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on-</p> <p>§483.95(c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12.</p> <p>§483.95(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property</p> <p>§483.95(c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on interview and review of other facility documentation it was determined that the facility failed to ensure that six (E18, E19, E20, E21, E22, and E23) out of eleven sampled employees received annual training on dementia management. Findings include:</p> <p>Review of facility training records for dementia training revealed six staff members without evidence of training within the past year:</p> <ul style="list-style-type: none"> - E18 (LPN) last training was on 8/30/18. E18 was hired on 8/19/15. - E19 (Activities) last training was on 3/28/18. E19 was hired on 3/28/18. - E20 (Social Worker) last training was on 12/14/17. E20 was hired on 12/14/17. - E21 (Medical Records) last training was on 3/23/18. E21 was hired on 2/18/09. 	F 943	<p>Corrective Measures for residents affected: Due to the nature of the issue, the facility cannot correct past practices.</p> <p>Measures to prevent recurrence: All facility staff to be educated on Dementia Care in the month of November. (Exhibit 26)</p> <p>Monitoring of corrective measures: Administrator or designee will complete audits to ensure that all staff are educated on dementia during the month of November. The audits will occur during the month of November. Audit results will be forwarded to the facility QAPI committee. (Exhibit 27)</p>	

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F 943	Continued From page 52 - E22 (COTA) no record of training. E22 was hired on 3/16/18. - E23 (CNA) last training was on 6/22/17. E23 was hired on 9/14/11. 10/17/19 2:40 PM - An interview with E2 (DON) revealed that the six employees did not have the required dementia training. These findings were reviewed during the exit conference on 10/21/19, beginning at 2:50 PM, with E2, E3 (ADON) and E1 (NHA, via phone).	F 943			



**DELAWARE HEALTH
AND SOCIAL SERVICES**

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

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

STATE SURVEY REPORT

Page 1 of 4

NAME OF FACILITY: **Delmar Nursing & Rehabilitation Center** DATE SURVEY COMPLETED: **October 21, 2019**

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE <i>12/16/2019</i>
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<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 and complaint survey was conducted at this facility from October 14, 2019 through October 21, 2019. The deficiencies contained in this report are based on observation, interviews, review of residents' clinical records and other facility documentation as indicated. The facility census the first day of the survey was 90. The survey sample totaled forty (40).</p> <p>Abbreviations/Definitions used in this report are as follows:</p> <p>ADON - Assistant Director of Nursing; CNA - Certified Nurse's Aide; DON - Director of Nursing; LPN - Licensed Practical Nurse; NHA - Nursing Home Administrator; OT- Occupational Therapy; RN - Registered Nurse;</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,</p>		
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Provider's Signature *Jessie Kussler* Title *Administrator* Date *11/13/2019*



**DELAWARE HEALTH
AND SOCIAL SERVICES**

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

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

STATE SURVEY REPORT

NAME OF FACILITY: Delmar Nursing & Rehabilitation Center DATE SURVEY COMPLETED: October 21, 2019

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE 12/16/2019
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3201.6.0	<p>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 October 21, 2019: F550, F641, F644, F646, F655, F656, F657, F660, F676, F693, F694, F698, F725, F842, F880, F883, and F943.</p>	<p><u>Corrective Measures for residents affected:</u></p> <p>Employee E28 is an employee of facility contracted Therapy Company. Two step PPD paperwork was forwarded to the facility. The 2 step was completed on 2/18/19.</p>	
3201.6.9	<p>Services To Residents</p>	<p><u>Identification of others with the potential to be affected:</u></p>	
3201.6.9.2	<p>Communicable Diseases</p>	<p>All staff have the potential to be affected. Nurse Educator or designee will complete an audit of all staff to ensure that 2 step PPD have been completed. (Exhibit DE1)</p>	
3201.6.9.2	<p>Specific Requirements for Tuberculosis</p>	<p><u>Measures to prevent recurrence:</u></p>	
6.9.2.4	<p>Minimum requirements for pre-employment tuberculosis (TB) testing require all employees to have a base line two step tuberculin skin test (TST) or single Interferon Gamma Release Assay (IGRA or TB blood test) such as QuantiFERon. Any required subsequent testing according to risk category shall be in accordance with the recommendations of the Centers for Disease Control and Prevention of the U.S. Department of Health and Human Services. Should the category of risk change, which is determined by the Division of Public Health, the facility shall comply with the recommendations of the Center for Disease Control for the appropriate risk category.</p> <p>This requirement is not met as evidenced by:</p> <p>Based on record review and interview it was determined that for one (E28) out of 15 employees reviewed, the facility failed to ensure all employees had a two-step tuberculin skin test pre-employment. Findings include:</p>	<p><u>Monitoring of corrective measures:</u></p> <p>Administrators or designee will complete audit to ensure the all staff received the 2 step PPD. The audits will occur on the following schedule: daily until 100% compliance is noted for five consecutive days, then three times a week until 100% compliance is noted for three consecutive weeks, then monthly until 100% compliance is noted for three consecutive months. Audit results will be forwarded to the facility QAPI committee. (Exhibit DE1)</p>	

Provider's Signature Reyn Kessler Title Administrator Date 11/13/2019



**DELAWARE HEALTH
AND SOCIAL SERVICES**

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

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Wilmington, Delaware 19806
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STATE SURVEY REPORT

NAME OF FACILITY: **Delmar Nursing & Rehabilitation Center** DATE SURVEY COMPLETED: **October 21, 2019**

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE <i>12/16/2019</i>
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<p>Title 16 Chapter 11 1162</p>	<p>Review of the completed survey form titled Personnel Audit Sheet revealed that E28 (OT) did not have results for a second tuberculin skin test. E28 was hired on 3/12/19.</p> <p>E3 (ADON) confirmed this finding on 10/24/19 at 4:12 PM in an email.</p> <p>Nursing Staffing</p> <p>a.) Every residential health facility must at all times provide a staffing level adequate to meet the care needs of each resident, including those residents who have special needs due to dementia or a medical condition, illness or injury. Every residential health facility shall post, for each shift, the names and titles of the nursing services direct caregivers assigned to each floor, unit or wing and the nursing supervisor on duty. This information shall be conspicuously displayed in common areas of the facility, in no fewer number than the number of nursing stations. Every residential health facility employee shall wear a nametag prominently displaying his or her full name and title. Personnel hired through temporary agencies shall be required to wear photo identification listing their names and titles.</p> <p>This requirement is not met as evidenced by:</p> <p>Based on observation and interview, it was determined that the facility failed to conspicuously display the titles of the nursing staff direct caregivers and the nursing supervisor assigned to each unit every shift for three (Unit 1, Unit 2 and Unit 3) out of four units. Findings</p>	<p><u>Corrective Measures for residents affected:</u></p> <p>Due to the nature of the issue, the facility cannot correct past practices.</p> <p><u>Measures to prevent recurrence:</u></p> <p>Managers and Scheduler to be educated on information that needs to be included on the daily staffing sheets that are posted on nursing units, which includes the staff titles. (Exhibit DE3)</p> <p><u>Monitoring of corrective measures:</u></p> <p>Administrator or designee will complete audits to ensure that all staff sheets include all required elements, which includes the staff titles. The audits will occur on the following schedule: daily until 100% compliance is noted for five consecutive days, then three times a week until 100% compliance is noted for three consecutive weeks, then monthly until 100% compliance is noted for three consecutive months. Audit results will be forwarded to the facility QAPI committee. (Exhibit DE4)</p>	
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Provider's Signature *[Signature]* Title Administrator Date 11/13/2019



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SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE 12/16/2019
	<p>include:</p> <p>10/14/19 from 9:30 AM to 10:00 AM – Observations of Units 1, 2 and 3 revealed a white board with staff assignments, but it did not include the titles of the staff (e.g., CNA, RN or LPN) or the name of the nursing supervisor on duty.</p> <p>10/15/19 from 11:00 AM to 11:15 AM – Observations of Units 1, 2 and 3 revealed a white board with staff assignments, but did it not include the titles of the staff (e.g., CNA, RN or LPN) or the name of the nursing supervisor on duty.</p> <p>10/16/19 from 9:18 AM to 9:30 AM - Observations of Units 1, 2 and 3 revealed a white board with staff assignments, but did it not include the titles of the staff (e.g., CNA, RN or LPN) or the name of the nursing supervisor on duty.</p> <p>10/18/19 3:30 PM – During an interview, E2 (DON) and E3 (ADON) confirmed the above findings and stated the required information would be added to the white board.</p> <p>These findings were reviewed during the exit conference on 10/21/19, beginning at 2:50 PM, with E2 (DON), E3 (ADON) and E1 (NHA, via phone).</p>		

Provider's Signature *Dee Kessler* Title Administrator Date 11/13/2019