DELAWARE HEALTH AND SOCIAL SERVICES
Division of Health Care Quality
Office of Long Term Care Residents Protection

DHSS - DHCQ
263 Chapman Road, Ste 200, Cambridge Bldg.
Newark, Delaware 19702
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: Delmar Nursing and Rehab Center **DATE SURVEY COMPLETED:** October 6, 2023

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced Annual, Complaint and Emergency Preparedness survey was conducted at this facility from September 29, 2023 through October 6, 2023. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census on the first day of the survey was 71. The survey sample totaled 18 residents.		
3201	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.0	**Scope**		
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** This requirement is not met as evidenced by: Cross Refer to the CMS 2567-L survey completed October 6, 2023: F641, F644, F656, F657, F686, F688, F695, F756, F761, F812, F814, F842.		

Provider's Signature Title Administrator Date 11/28/23

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3201.6.9.2 3201.6.9.2.4	**Specific Requirements for Tuberculosis** **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 Dis-ease 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. While the requirement for a two step is waived, facilities must complete a one-step TB test upon employment.** Based on interview and review of personnel records, it was determined that the facility failed to ensure that four (E8, E9, E10 and E11) out of twelve (12) employees reviewed, received their pre-employment tuberculosis screening completed. Findings include: 10/4/23 – Review of the Employee Tuberculosis information documented on the facility's personnel spreadsheet revealed the following: 1. E8's (CNA) first day in the facility was 6/7/22. E8's results of the first PPD were documented as 6/9/22. 2. E9's (CNA) first day in the facility was 11/2/21. E9's results of the first PPD were documented as 11/5/21.	Corrective measures for residents affected: No residents identified affected. Identification of others with the potential to be affected: Audit completed for all hired and newly hired staff in all departments. Measures to prevent recurrence: Clinical staff educated on updated policy for TB screening to include all newly hired staff to complete a two-step tuberculin skin test prior to first day of employment. Monitoring of corrective measures: ***Human resources or designee to assure all newly hired staff will complete a two-step tuberculin skin test prior to scheduling orientation.***	11/01/23

Provider's Signature [signature] Title Administrator Date 11/28/23

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	3. E10's (Activities Aide) first day in the facility was 6/14/22. E10's results of the first PPD were documented as 11/24/22. 4. E11's (CNA) first day in the facility was 6/17/22. E11's results of the first and second PPD were not available. 10/4/23 2:35 PM – An interview with E7 (Staff Educator) revealed there was no information for E11's PPD result because the agency they work for does not require them to do a PPD test. 10/6/23 1:20 PM – An interview with E2 (DON) revealed new employees receive their first PPD during their orientation education training, however they will work with residents prior to receiving the results back. Findings were reviewed with E19 (NHA), E1 (NHA in training), E2 (DON) and E3 (Unit Manager) at the exit conference on October 6, 2023, at 1:55 PM.		

Provider's Signature [signature] Title Administrator Date 11/28/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085041	A. BUILDING _____ B. WING _____	C 10/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR NURSING & REHABILITATION CENTER	101 DELAWARE AVE., DELMAR, DE. 19940-1110 DELMAR, DE 19940

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E 000	Initial Comments An unannounced annual and complaint survey was conducted at this facility from September 29, 2023 through October 6, 2023. The facility census was 71 on the first day of the survey. In accordance with 42 CFR 483.73, an Emergency Preparedness survey was also conducted by The Division of Health Care Quality, the Office of Long-Term Care Residents Protection at this facility during the same time period. Based on observations, interviews, and document review, no Emergency Preparedness deficiencies were found.	E 000		
F 000	INITIAL COMMENTS An unannounced Annual, Complaint and Emergency Preparedness survey was conducted at this facility from September 29, 2023 through October 6, 2023. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census on the first day of the survey was 71. The survey sample totaled 18 residents. CNA - Certified Nursing Assistant; DON - Director of Nursing; NHA - Nursing Home Administrator; NP - Nurse Practitioner; OT - occupational therapist; RN - Registered Nurse; SW - Social Worker; UM - Unit Manager; Activities of daily living (ADLs) - tasks needed for daily living, e.g. dressing, hygiene, eating, toileting, bathing;	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 11/01/2023

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 Anxiety - general term for several disorders that cause nervousness, fear, apprehension and worrying or Anxiety is an unpleasant state of inner turmoil, often accompanied by nervous behavior, such as pacing back and forth; Anoxic brain damage - brain loses oxygen supply, which results in the death of brain cells; BIMS - (Brief Interview for Mental Status) - Assessment of the resident's mental status. The total possible BIMS Score ranges from 0 to 15 with 15 being the best. 0-7: Severe impairment (never/rarely made decisions) 08-12: Moderately impaired (decisions poor; cues/supervision required) 13-15: Cognitively intact (decisions consistent/reasonable); Bipolar Disorder - mood disorder; BLE - bilateral lower extremities; Braden Scale - tool used to determine risk for development of pressure ulcers; Centimeter (cm) - Centimeter - a metric measurement of length, 1 centimeter = 0.39 inches; Contracture - joint limitations with fixed high resistance to passive stretch of a muscle; Deep Tissue Injury (DTI) - A type of pressure ulcer that appears purple or maroon and is a localized area of discolored intact skin. May be preceded by tissue that is painful, mushy, firm, boggy (wet, spongy feeling), warmer or cooler than adjacent tissue; Delusional disorder - A serious mental illness previously called paranoid disorder, in which a person can't tell real from what is imagined; Dementia - A severe state of cognitive impairment characterized by memory loss, difficulty with abstract thinking, and disorientation OR loss of mental functions such as memory and	F 000		

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F 000	Continued From page 2	F 000		

reasoning that is severe enough to interfere with a person's daily functioning;
Denude - loss of outermost layer of the skin;
Dx - Diagnosis;
Extensive assistance - the individual would not be able to perform or complete the activity of daily living (ADL) without another person to aid in performing the complete task, by providing weight-bearing assistance;
Fifth (5th) Toe - the outermost toe or called the "little toe," "pinky toe," or "baby toe;"
Generalized - spread or extended throughout the body;
Gerichair - wheelchair type of chair that reclines;
Heel or ankle boot - A pillow-like boot that covers the entire foot and provides low friction cushioning to the heel;
L - Liter;
Lateral - farther from the median; relating to the side;
Lesion - An area of altered or diseased tissue;
Major Depressive Disorder - also known as depression, is a mental disorder characterized by at least two weeks of low mood that is present across most situations. It is often accompanied by low self-esteem, loss of interest in normally enjoyable activities, low energy, and pain without a clear cause;
MDS assessment - Federally mandated comprehensive, standardized, clinical assessment of all residents in Medicare/Medicaid nursing homes that evaluates functional capabilities and health needs;
Medication Regimen Review (MRR) - monthly review by pharmacist of resident's medications, laboratory tests and any records necessary to determine whether or not irregularities exist;
NC - nasal cannula - Tube placed into nostrils to deliver oxygen;

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F 000	Continued From page 3 O2 - Oxygen; Palm Protector/Guard - offer relief from curling fingers, hand contractures and cramping; PASARR - Preadmission Screening and Resident Review - screening for evidence of serious mental illness and/or intellectual disabilities, developmental disabilities or related conditions. to ensure that individuals are thoroughly evaluated and they are placed in nursing homes only when appropriate and that they receive all necessary services while they are there; Pressure Reduction Device - cushion; Pressure Ulcers (PUs) - sore area of skin that develops when the blood supply to it is cut off due to pressure; Pressure Ulcer Stage IV (4) - A stage of a Pressure ulcer where the ulcer has become so deep that there is damage to the muscle and bone and sometimes to tendons and joints; Psychotic disorder(s) - severe mental disorders that cause abnormal thinking and perceptions; ROM (range of motion) - the measurement of movement around a specific joint or body part; Sacrum - large triangular bone at base of spine; Saturation/sats- the measure of the amount of hemoglobin that is bound to a molecular oxygen at a given time point; Schizophrenia - mental disorder with false beliefs of being harmed; Slough - yellow, tan, gray, green or brown dead tissue; SOB - Shortness of breath; Splint - a rigid or flexible device that maintains in position a displaced or movable part; Stroke - a medical condition in which poor blood flow to the brain causes cell death; Subcutaneous - beneath, or under, all the layers of the skin; Unstageable - A stage of a pressure ulcer where	F 000		

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F 000	Continued From page 4 the tissue loss in which actual depth of the ulcer is unable to be determined due to the presence of slough (yellow, tan, gray, green or brown dead tissue) and/or eschar (dead tissue that is tan, brown or black and tissue damage more severe than slough in the wound bed). UTD - unable to determine; Wedge (pillow) - A relatively firm foam cushion that forms an acute angle opposite the base used to prop up their head and neck or support their back and shoulders when in bed. They can also be used to elevate the legs and help improve circulation;	F 000		
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 of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §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. §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: Based on interview and record review, it was	F 644	Corrective measures for residents	11/27/23

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F 644	Continued From page 5 determined that for three (R10, R12 and R16) out of three residents reviewed for PASARR, for R10, R12, and R126 the facility failed to ensure that a referral for a PASARR screening was completed following a new diagnosis of psychotic disorder which was not listed on the previous PASARR. Findings include: 1. Review of R10's clinical record revealed: 3/24/14 - R10 was admitted to the facility. 3/25/14 - A review of R10's medical record revealed a PASARR level I was completed prior to admission. 7/17/18 - A review of R10's medical record revealed that R10 had a PASARR level I that indicated R10 had a documented serious mental illness (depression and anxiety) and demonstrated a full level II was not indicated at that time. 8/29/19 - A review of R10's medical record revealed that R10 had the following new diagnoses: bipolar disorder, major depressive disorder, anxiety disorder, and delusional disorder. 9/20/19 - A review of the MDS revealed diagnosis of bipolar, major depressive disorder, anxiety disorder, and delusional disorder were documented. 10/4/23 2:45 PM - An interview with E4 (social worker) confirmed that a PASARR level II was never requested for R10.	F 644	affected: Social Worker submitted a PASARR screen for residents R10, R12 and R16. Facility obtained new PASRR screens for R10, R12, R16 and patients charts were updated to reflect. Identification of others with the potential to be affected: All residents have the potential to be affected. Social Worker, or designee, will complete an audit of all current residents to ensure that PASARRs reflect current diagnosis and medications with resubmission of PASARR, if needed (Exhibit 2). Measures to prevent recurrence: Root cause analysis revealed PASRR screening was not completed following a new diagnosis of psychotic disorder. Staff educator or designee educated managers on need to notify Social Worker related to all changes in diagnoses, medication and behaviors to determine need for resubmission of PASRR (Exhibit 1). Daily morning IDT report to include review of pharmacy recommendations, diagnoses, and behaviors and also reviewed during weekly high risk meeting. Monitoring of corrective measures: Administrator, or designee, will be responsible for auditing for compliance until 100 % compliance is achieved for 10	

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F 644	Continued From page 6 2. Review of R16's clinical record revealed: 2/27/13 - R16 was admitted to the facility. 2/25/13 - An admission PASARR level I was completed for R16. 7/30/18 - A repeat PASARR level I was completed that indicated R16 had a documented serious mental illness (Schizophrenia) and demonstrated a full level II was not indicated at that time. 2/22/19 - A review of R16's medical record revealed that persistent mood disorder was added to R10's diagnoses. 7/12/19 - A review of R16's medical record revealed that delusional disorder was added to R10's diagnoses. 8/23/19 - A review of R16's medical record revealed that bipolar disorder and mood disorder was added to R10's diagnoses. 11/13/19 - An MDS (Minimum Data Set) was completed for R16 and indicated that R16 had delusional disorder, persistent mood disorder, bipolar disorder and mood disorder. 10/4/23 2:45 PM - An interview with E4 confirmed that a PASARR level II was never requested for R16. 3. Review of R12's clinical record revealed: 3/2/12 - R12 was admitted to the facility. 3/2/12 - Review of R12's clinical record revealed that R12 had a PASARR Level 1 completed.	F 644	consecutive residents followed by random audits of 10 residents per month for 3 months with 100% compliance. Audit results will be forwarded to the Facility QAPI Committee (Exhibit 3).	

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F 644	Continued From page 7 9/3/19 - Review of R12's medical record revealed that upecified psychosis, dementia without behavioral disturbances, delusional disorder, and anxiety disorder was added to R12's diagnoses. 9/30/23 - An annual MDS assessment was completed for R12 and indicated that R12 had anxiety disorder, depression, psychotic disorder, and delustional disorder. 10/4/23 9:39 AM - During an interview E4 (Social worker) confirmed R12 had a PASARR Level I on admission and that a PASSR Level II was not requested for R12. 10/5/23 1:35 PM - In an email correspondence, S1 (PASARR State Authority) revealed that, "...The facility should have submitted a status change or another resident review PASARR at that time of or timely discovery that the Level 1 (Notice Date 7/30/18) was not an accurate reflection of (R 10 and 16's) mental health status and new diagnoses." Findings were reviewed with E19 (NHA), E1 (NHA in training), E2 (DON) and E3 (Unit Manager) at the exit conference on 10/6/23 at 1:55 PM.	F 644		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §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	F 656		11/27/23

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F 656	Continued From page 8 medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by:	F 656		

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F 656	Continued From page 9 Based on observation, interview, and record review, it was determined that for three (R53, R58 and R67) out of eighteen (18) residents reviewed for care plans, the facility failed to accurately assess and document R53's dental status. For R67 and R58 the facility failed to include the use of heel boots and pxygen use. Findings include: 1. Review of R67's clinical record revealed: 8/17/23 - R67 was admitted to the facility. 8/18/23 - An initial comprehensive careplan was completed for R67. 8/29/23 - A physician's order for "O2 at 2L/min via nc (nasal cannula) as needed for SOB (shortness of breath) and to maintain O2 sats above 88%" was entered. 10/4/23 - A review of R67's care plan dated 8/18/23 for respiratory function failed to include evidence of oxygen use. 10/5/23 approximately 10:25 AM - E2 (DON) confirmed that R67's oxygen use was not included on the care plan. 2. Review of R53's clinical record revealed: 10/3/21 - R53 was admitted to the facility. 10/16/21 through 10/5/23 - Care plans for dental status documented R53 had "no natural teeth or tooth fragment(s) edentulous" (lacking teeth, toothless). 10/3/23 approximately 11:00 AM - During an	F 656	Corrective measures for residents affected: R67 care plan was updated to reflect the usage of oxygen therapy by nurse manager per physician order. Resident R53 care plan for dental status documented no natural teeth, dental assessment completed by nurse manager, and care plan updated to reflect current dental status. Therapy evaluation completed for R58 on 10/05/23 by Physical therapist with recommendations for pressure relieving foam boots to be placed at bilateral lower extremities. R58 provided with bilateral pressure relieving boots by therapy to be in place to BLE at all times except during care, care plan updated. Identification of others with the potential to be affected: Director of Nursing, or designee, conducted a full house audit and identified residents with pressure relieving devices, those with oxygen usage, and dental status. Audit included care plan and order review for those residents that require the usage of oxygen. Clinical review of all residents for dental status. Therapy recommendations and orders reviewed for pressure relieving devices for all residents with appropriate evaluations completed to determine need and usage (Exhibit 4, 5, & 6). Measures to prevent recurrence:	

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F 656	Continued From page 10 interview, R53 stated that he had some natural teeth on the bottom, pointed to a tooth and stated that one was cracked when he came in, but since then it had been fixed. R53 proceeded to say that he wears full upper dentures and sees the dentist on a regular basis. 10/5/23 3:35 PM - During an interview, E2 (DON) and E6 (Unit Manager) confirmed R53's care plan lacked evidence that a person-centered care plan with interventions was developed to accurately reflect R53's dental status. E2 and E3 (ADON) both confirmed that R53 had natural bottom teeth and full upper dentures. 3. Review of R58's clinical record revealed: 4/20/22 - R58 was admitted to the facility with diagnoses of anoxic brain damage and generalized muscle weakness. 9/1/22 - A physical therapy discharge summary written by E12 (Physical Therapist) documented: "Splint / Orthotic Recommendations: BLE ankle boots recommended to prevent further contractures and heels/ankles floating to nearest possibility to prevent skin breakdown." 3/15/23 - A review of R58's care plan included to have boots to both feet to be worn at all times except during care, effective 3/8/23. 10/4/23 11:00 AM - An interview with E14 (CNA) confirmed R58 was wearing just one heel boot and they were unaware of any interventions to offload R58's heels. When asked when the intervention to use a right heel boot began for R58, E14 stated, "I think it was about one or two weeks ago, I don't know where it came from."	F 656	Root cause analysis revealed baseline care plan was not reviewed properly during clinical IDT for R67 with significant change of condition. R53 was found to have improper assessment at time of his admission to facility. R53 quarterly assessments did not accurately identify patients' dental records. Review of R58 care plan revealed discrepancy between nursing orders and therapy recommendations. Resident Care plans to be reviewed with IDT at time of admission. Long term resident's assessments to be reviewed at quarterly care plans scheduled according to OBRA and/or at time of documented significant changes. Director of Rehab to utilize therapy to nursing communication forms and review during morning IDT meetings. Licensed nursing staff to be educated by staff educator or designee that all residents require an individualized comprehensive care plan (Exhibit 7). Resident care plans to be reviewed with Interdisciplinary Team (IDT) at time of admission, and as needed. Long term care resident's assessment to be reviewed at quarterly care plans scheduled according to OBRA and/or at time of documented significant changes. Director of Rehabilitation to share nursing communication form with recommended changes to resident plan of care (POC) to be reviewed daily at morning IDT, orders and care plans to be review and updated. Physician's orders and assessments to be reviewed daily in morning IDT meeting, care plans to be reviewed and updated accordingly.	

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F 656	Continued From page 11 An interview on 10/4/23 at 12:02 PM with E6 (Unit Manager) confirmed for R58 to have boots to feet at all times. The facility failed to include inteventions for bilateral heel boots to prevent further contraction and skin breakdown for R58. Findings were reviewed with E19 (NHA), E1 (NHA in training), E2 (DON) and E3 (Unit Manager) at the exit conference on 10/6/23 at 1:55 PM.	F 656	Monitoring of corrective measures: Director of Nursing, or designee, to document number of resident care plan reviewed and compare to number of scheduled care plans and document results in QAPI to assure success. Physician order and assessments review audit completed for 10 residents for oxygen, pressure relieving devices and dental status for 5 days until 100% compliance, then 3 times a week for 3 weeks until 100% compliance, thereafter monthly for 3 months. Audit results will be forwarded to the Facility QAPI Committee (Exhibit 8).	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (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	F 657		11/27/23

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F 657	Continued From page 12 not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that for two (R15 and R46) out of eighteen residents reviewed for care plans, the facility failed to update these residents' care plans to reflect the use of insulin. 1. Review of R46's clinical record revealed: 2/17/20 - Resident was admitted to the facility. 3/9/21 - R46's care plan for diabetes was completed. 12/1/22 - A medication order was entered, as follows: "Levemir FlexTouch U-100 Insulin 100 unit/mL (3 mL) subcutaneous pen ...: inject 4 units by subcutaneous route once daily." 8/29/23 - R46's most recent care plan meeting was convened. 10/4/23 untimed - Review of R46's care plan revealed there was no reference to insulin usage. 10/5/23 at approximately 10:25 AM - During an interview with E2 (DON), she confirmed there was no care plan for R46's use of insulin.	F 657	Corrective measures for residents affected: Surveyor reviews of R15 and R46 comprehensive care plan did not reflect use of prescribed insulin. Nurse manager reviewed and care plan was updated to reflect insulin usage for both R15 and R46. Identification of others with the potential to be affected: All residents that are diabetic with insulin orders have the potential to be affected. Unit Manager, or designee, completed audit of all diabetic residents with insulin orders to enhance accuracy (Exhibit 9). Measures to prevent recurrence: Root cause analysis revealed comprehensive care plans not updated to physician order changes. Physician orders to be clinically reviewed and care plans to be updated accordingly during IDT meetings Based on a review of current processes, the process will be enhanced	

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F 657	Continued From page 13 2. Review of R15's clinical record revealed: 7/18/19 - R15 was admitted to facility. 2/16/23 - A care plan for diabetes was initiated and revealed R15 was a controlled diabetic taking oral hypoglycemics (medication to control blood sugar) and diet controlled. 7/26/23 12:52 PM - A physician's order was written for Lispro insulin three times a day with meals. Also, for Lispro sliding scale three times a day with finger sticks and written for Lantus insulin at bedtime. 7/26/23 3:52 PM - A care plan was updated but did not include insulin. 10/04/23 1:50 PM - An interview with E3 (UM) confirmed that R15's care plan did not include use of insulin to reflect R15's current needs. The facility failed to update R15's and R46's care plan to reflect the current need of insulin. Findings were reviewed with E19 (NHA), E1 (NHA in training), E2 (DON) and E3 (Unit Manager) at the exit conference on 10/6/23 at 1:55 PM.	F 657	to have all physician orders clinically reviewed and care plans updated accordingly during daily IDT meetings. Staff educator or designee to educate all licensed clinical staff on updating care plans with insulin usage according to physician order changes (Exhibit 10). Physician's orders and assessments to be reviewed daily in morning IDT meeting, care plans to be reviewed and updated accordingly. Monitoring of corrective measures: Director of Nurses, or designee, will be responsible for auditing compliance daily for 5 days, then 3 times a week for 3 weeks, and monthly for 3 months until 100% compliance is achieved (Exhibit 11). Audit results will be forwarded to the Facility QAPI Committee.	
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure	F 686		11/3/23

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F 686	Continued From page 14 ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined that for two (R58 and R14) out of two residents reviewed for pressure ulcers, the facility failed to provide care and services to promote healing and prevent pressure ulcers. For R58 the facility failed to prevent an avoidable deep tissue injury from developing to the left heel and a stage 4 pressure ulcer to the right ankle causing harm. For R14 the facility failed to ensure that the resident was turned and repositioned to prevent pressure ulcers. Findings include: National Pressure Ulcer Advisory Panel (NPUAP), Prevention and Treatment of Pressure Ulcers: Quick Reference Guide, second edition, published 2014, stated "Do not position an individual directly on a pressure ulcer...Continue to turn and reposition the individual regardless of the support surface in use...No support surface provides complete pressure relief." An undated facility policy titled "Pressure Ulcer Prevention" included: A determination that development of a pressure ulcer was unavoidable may be made only if routine preventative and daily care was provided. Routine preventive care means turning and proper positioning, application of pressure reduction devices .... Residents at risk should be turned and repositioned at least	F 686	Corrective measures for residents affected: Residents R58 and R14 were evaluated by therapy and physician to review current plan of care and revise as needed. R58 has preventative measures in place such as pressure relieving boots to bilateral feet provided, long wedge, low loss air mattress, turn and reposition schedule and nutritional supplements. R58 and R14 are on turning and repositioning schedules with measures put in place to ensure compliance with measure. Director of Nursing or designee completed whole house audit of Braden score with head-to-toe skin assessments with direct observation and record review for all residents. Identification of others with the potential to be affected: Director of nursing completed record and review with direct observation of each resident to include turning and reposition, resident Braden scale, current skin intervention and determined if additional skin interventions needed to implemented. All residents have the potential to be	

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F 686	Continued From page 15 every two hours or more frequently depending on other risk factors ...." 1. Review of R58's clinical record revealed: 4/20/22 - R58 was admitted to the facility with diagnoses of anoxic brain damage and generalized muscle weakness. 4/20/22 - A nursing admission Braden Scale documented R58 with a score of 14 (13 - 14 is considered moderate risk of skin breakdown). 5/2/22 - The electronic record documented R58's diagnoses of disorder to the skin and subcutaneous tissue and contracture of the right/left shoulder, right/left elbow and right/left hand. a. 9/1/22 - A physical therapy discharge summary written by E12 (Physical Therapist) documented: "Splint / Orthotic Recommendations: BLE ankle boots recommended to prevent further contractures and heels/ankles floating to nearest possibility to prevent skin breakdown." The quarterly MDS for 10/28/22 and 1/28/23 documented that R58 was totally dependent on one staff person to turn and reposition with no pressure ulcers and was at risk of developing pressure ulcers. R58 had one lesion on the foot (trauma to the left, second toe) and one open lesion other than ulcers, rashes, cuts (abscess to the sacrum). The MDS also documented R58 had a pressure reducing device for the chair and bed; was on a turning and repositioning program; applications of nonsurgical dressings, ointments/medications, other than to the feet and application of dressings to the feet. The 1/28/23	F 686	affected. All resident's Braden scales reviewed to determine residents at risk for skin impairments and review of possible additional interventions to include pressure reducing devices (Exhibits 12 & 13). Each residents Braden scale reviewed, identified current preventive measures, and identified additional measures to be put into place. Measures to prevent recurrence: Root cause analysis revealed R58 did not have all preventive pressure relieving interventions in place. R58 and R14 found not to be appropriately turned and repositioned according to physician orders. Director of Nurses completed audits of all residents that require assistance with turning and repositioning, audit including direct observation and documentation of turning and repositioning of residents at different time frames. Staff educator or designee provided education to licensed staff on completing and analyzing Braden scale and initiating interventions (Exhibit 14). Facility process to be enhanced with the Braden assessment and diagnoses to be reviewed by clinical team including DON, ADON, and unit managers upon admission, quarterly, annually and at time of significant change. All interventions to be reviewed to ensure accuracy and appropriateness. All clinical staff and certified nursing aides are to be educated on the need to report any changes to a resident's mobility or skin integrity	

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F 686	Continued From page 16 quarterly MDS was updated to include an additional intervention to receive nutrition or hydration interventions to manage skin problems. A review of R58's care plan last revised 1/25/23 included to turn and reposition every two hours with skin checks and an air loss mattress, effective 4/25/22. The care plan did not include interventions for R58 to wear heel boots to both feet or offload the heels. 3/6/23 - A nursing Braden Scale documented R58 with a score of 14 (13 - 14 is considered moderate risk). 3/13/23 - A nursing progress note documented that R58 had two new wound areas. The first area was a wound to the left heel that is discolored and measures 1.5 cm x 3 cm. The second area was a wound located on the right outer ankle "that was not there yesterday ...has open area with denuded skin that measures 3 cm x 2 cm x [undetermined depth] has red/yellow slough." The progress notes also stated that a therapy referral for positioning would be made. 3/13/23 - A wound evaluation form documented a pressure wound to the right outer ankle with an undetermined depth stage and measurements of 3 cm x 2 cm x undetermined depth. A deep tissue injury wound to the left heel with measurements of 1.5 cm x 3 cm x 0 cm. The document listed multiple treatments including turn resident to back and left side only. 3/15/23 - A review of R58's care plan included to always wear boots to feet except during care, effective 3/8/23.	F 686	immediately. Weekly skin assessments to be completed by nursing. Turning and repositioning orders are found in CNA tasks list in the EMR and going forward will be included in the Nurse Aide Care Card book (Exhibit 15). Facility utilizes a wound care team to monitor residents who have pressure ulcers weekly. Newly completed Braden scales to be reviewed daily during morning IDT reports and interventions to be put in place as appropriate. Monitoring of corrective measures: Director of Nursing, or designee, will complete direct observation audits of turning and repositioning, pressure relieving devices to ensure device are in place and record review of Braden assessments daily to ensure all appropriate interventions are in place for 5 days, then 3 times a week for 3 weeks, then weekly time 3 months, and then monthly of 30% of the population identified until 100% compliance is achieved (Exhibit 16). Audit results will be forwarded to the Facility QAPI Committee.	

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F 686	Continued From page 17 3/15/23 - A physical therapy evaluation was completed for R58 "in order to improve ability to exhibit preserved skin integrity and relieve pressure for decreased risk of skin breakdown ...." The facility lacked evidence that the heel boots were applied to R58 from the time it was recommended by therapy on 9/1/22 until the boots were added to the care plan updated on 3/15/23. 3/24/23 - A wound evaluation form documented the wound to the right lateral ankle as a stage 4 pressure wound. The left heel wound was documented as a deep tissue injury. 10/6/23 9:33 AM - During an interview, E12 confirmed the heel boots were recommended for continued use after therapy discharge. E12 stated "we used the heel boot to prevent pressure to the heel, we wanted to offload his heels." 10/6/23 at 9:40 AM - During an interview E6 (Unit manager), confirmed the therapy discharge summary recommendations were reviewed on 9/1/22. E6 stated that the rehabilitation department gives nursing a copy of the summary and the unit manager or the nurse signs them and puts the orders or the recommendations in the treatment interventions in the electronic chart. E6 stated, "we would follow the recommendations from therapy as they provide it." R58 developed two avoidable pressure ulcers to both feet. The facility lacked evidence of using the heel boots that were recommended by the therapy department on 9/1/22. Additionally the facility failed to provide any other interventions to	F 686		

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F 686	Continued From page 18 offload pressure to the feet. The facility failed to include the heel boots as a prevention of skin breakdown until 3/15/23, over six months later resulting in harm to the resident when R58 developed two pressure ulcers to both feet. b. 3/15/23 - A review of R58's care plan included to always wear boots to feet except during care, effective 3/8/23. On the following dates and times, R58 was observed lying in bed with left foot resting directly on the mattress without the left heel boot: 10/3/23 at 9:14 AM, 10/3/23 at 10:34 AM, 10/3/23 at 12:37 PM, 10/3/23 at 1:14 PM and 10/3/23 at 2:22 PM. 10/4/23 11:00 AM - During an interview with E14 (CNA) revealed that the heel boot to right foot started one or two weeks ago. It was further revealed E14 was not aware of where boot came from for R58. There was no further information offered about the left heel boot. 10/4/23 at 12:02 PM - An interview with E6 (Unit Manager) confirmed R58 should have boots on both feet at all times. 10/5/23 1:07 PM - An interview with E15 (Nurse Practitioner) confirmed that R58's heels were to be offloaded at all times. 10/6/23 9:33 AM - During an interview with E12 (therapist) confirmed the heel boots were recommended for R58' s continued use after R58' s therapy discharge on 9/1/22. E12 stated "we used the heel boot to prevent pressure to the heel, we wanted to offload R58's heels."	F 686		

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F 686	Continued From page 19 The facility failed to ensure R58 with a history of pressure ulcers had a left heel boot to his feet to prevent skin breakdown. 2. Review of R14's clinical record revealed: 6/23/21 - R14 was admitted to facility. 6/24/21 - A nursing admission Braden Scale documented R14 with a score of 15 (15 - 18 is considered mild risk of skin breakdown). 12/23/22 - The electronic record documented R14's diagnoses of stroke, generalized muscle weakness, contractures of left hip, left knee, left and right hand. A review of R14's care plan last revised 6/21/23 included to turn and reposition every two hours with skin checks, effective 3/20/23. 9/23/23 - R14's quarterly MDS documented that R14 was an extensive assist of two or more staff for turning and repositioning. The MDS also documented R14 had a pressure reducing device for the chair and bed and was on a turning and repositioning program. 10/4/23 9:10 AM - During an interview with R14, when asked if she gets turned on her side, she replied "no." On the following dates and times, R14 was observed in bed laying on her back on 10/4/23: 9:10 AM, 10:30 AM, 11:20 AM, 12:36 PM and 1:11 PM. R14 was observed lying in bed on her back for four hours without any turning.	F 686		

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DELMAR NURSING & REHABILITATION CENTER	101 DELAWARE AVE., DELMAR, DE. 19940-1110 DELMAR, DE 19940

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F 686	Continued From page 20 10/5/23 10:48 AM - During an interview E6 (UM) confirmed R14's was to be turned and repositioned every two hours. The facility failed to ensure that R14 was turned and repositioned every two hours. Findings were reviewed with E19 (NHA), E1 (NHA in training), E2 (DON) and E3 (Unit Manager) at the exit conference on 10/6/23, at 1:55 PM.	F 686		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that for two (R14 and R58) of four residents reviewed for ROM/mobility, the facility failed to provide care to maintain or	F 688	Corrective measures for residents affected: R14 palm protective device on right hand	11/27/23

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F 688	Continued From page 21 prevent further decline in function/mobility. Findings include: An undated facility policy titled "Pressure Ulcer Prevention" included: Routine preventive care means turning and proper positioning, application of pressure reduction devices .... Residents at risk should be turned and repositioned at least every two hours or more frequently depending on other risk factors .... The use of soft foam devices (i.e. carrots, palm protectors, etc.) should be considered to alleviate pressure if the resident has a contracted hand after appropriate evaluation by OT for device orders and application instructions." 1. Review of R14's clinical record revealed: 6/23/21 - Admission of R14 to facility. 12/23/22 - The electronic record documented R14's diagnoses of stroke, generalized muscle weakness, contractures of left hip, left knee, left hand and right hand. A review of R14's care plan last revised 6/21/23 included to always wear palm guard to right hand except during hygiene and meals, effective 8/10/21. 9/23/23 - R14's quarterly MDS documented that R14 had an impairment on both sides for the upper extremities and the lower extremities for functional range of motion. 9/29/23 10:50 AM - During an interview with E16 (CNA), when asked if R14 wears or uses any kind of devices on her hands E16 stated, "she does not have any."	F 688	was immediately put into place as ordered by therapy. Staff educator or designee provided staff education. R58 wedge was immediately put in place by therapist. Staff educator or designee provided staff education and measures in place to ensure compliance. Identification of others with the potential to be affected: All residents who have palm guards and wedges have potential to be affected. Unit Manager, or designee, completed direct observation audit and assessment as needed on palm guards, wedges, and other pressure relieving and ROM devices to ensure compliance with resident's individualized POC (Exhibit 17). Measures to prevent recurrence: Facility root cause analysis revealed staff unable to identify processes to determine which residents required palm protectors and wedges. Staff educator or designee to provide education to clinical staff and CNA's on how to locate assistive device orders within EMR. Nurses responsible for CNA's proper utilization and documentation for donning and/or resident refusals (Exhibit 18). Monitoring of corrective measures: Director of Nursing, or designee, will complete direct observation audit of palm guards, pressure relieving boots, and wedges to assure devices are in place	

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F 688	Continued From page 22 10/3/23 10:22 AM and 11:36 AM - R14 was observed without a palm guard on the right hand. 10/4/23 10:30 AM - R14 was observed without a palm guard on the right hand. 10/4/23 11:00 AM - During an interview, E14 (CNA) stated there was no place in the electronic record or any other place to document applying devices including splints or guards for the residents. 10/4/23 11:20 AM, 12:36 PM and 2:20 PM - R14 was observed without a palm guard on the right hand. 10/5/23 10:14 AM - During an interview, E17 (Rehab Director) confirmed R14 has an active treatment to use a right palm protector. E17 stated, "we have her documented that she refuses ...she is on my splint list as not compliant with it ...it [right palm protector] started 8/9/21 ...they [CNA's] are still supposed to attempt to try to have her wear it every day." 10/5/23 10:43 AM - E17 was observed placing a palm protector device on R14's right hand. E17 confirmed the device not being present and stated "she [R14] put it on very well and we are considering bringing her back in therapy." E17 confirmed that R14 did not refuse the palm protector. 10/5/23 10:48 AM - During an interview E6 (UM) confirmed R14 is "supposed to wear a palm protector and if not to document a refusal in the progress notes... if refused, it will be documented in the care plan as a refusal."	F 688	according to physician orders for 5 days, then 3 times a week for 3 weeks, and monthly for 3 months until 100 % compliance (Exhibit 19). Audit results to be forwarded to the Facility QAPI Committee.	

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F 688	Continued From page 23 The facility lacked evidence in the clinical record or the care plan that R14 refused wearing the palm guard. The facility failed to apply R14's palm guard to maintain ROM and prevent further contracture. 2. Review of R58's clinical record revealed: 4/20/22 - R58 was admitted to the facility with a diagnoses of anoxic brain damage and generalized muscle weakness. 5/2/22 - The electronic record documented R58's diagnoses of disorder to the skin and subcutaneous tissue and contracture of the right/left shoulder, right/left elbow and right/left hand. A review of R58's care plan last revised 7/19/23 included interventions for the resident to be out of bed to geri-chair for positioning and comfort, effective 4/26/22. The care plan also included an intervention for wedges to be used for positioning, which was effective 8/17/22. The care plan also included to turn and position R58 to back and left side only, every two hours and as needed with skin checks. 7/29/23 - R58's quarterly MDS documented R58 had an impairment on both sides for the upper extremities and the lower extremities for his functional range of motion. The MDS also documented R58 was totally dependent of one staff for turn and reposition and was totally dependent of two or more staff for transferring from bed to chair.	F 688		

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F 688	Continued From page 24 9/4/23 - An occupational therapy progress report documented R58 uses a small wedge for his right lower extremity to maintain good positioning in bed and reduce risk of skin breakdown, beginning on 5/24/23. On the following dates and times, R58 was observed in bed laying on his back without any wedges in place: 10/3/23 at 9:14 AM, 10/3/23 at 10:34 AM and 10/3/23 at 12:37 PM. 10/3/23 2:22 PM - R58 was observed in bed laying on his back without any wedges in place. 10/3/23 - R58 remained on his back from 9:14 AM to 2:22 PM without ever being repositioned with the wedges. 10/4/23 9:10 AM - R58 was observed in bed laying on his back without any wedges in place. The facility failed to reposition R58, a totally dependent resident, with a history of contracture, from back to left side every two hours using wedges to prevent further contracture. Findings were reviewed with E19 (NHA), E1 (NHA in training), E2 (DON) and E3 (Unit Manager) at the exit conference on 10/6/23 at 1:55 PM.	F 688		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of	F 695		11/27/23

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F 695	Continued From page 25 practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that for one (R67) out of three residents reviewed for respiratory care, the facility failed to ensure that R67 oxygen tubing was changed. Findings include: An undated facility policy for oxygen use stated "Tubing change - Oxygen cannula tubing ....is charted weekly and prn (as needed). Review of R67's clinical record revealed: 8/17/23 - R67 was admitted to the facility. 8/29/23 - A physician's order for "O2 at 2L/min via nc (nasal cannula) as needed for SOB (shortness of breath) and to maintain O2 sats above 88%". 9/29/23 11:49 AM - An observation revaled that R67's oxygen tubing was not labeled on the following dates and time: 9/29/23 11:49 AM; 10/4/23 at 9:27 AM; and 10/5/23 at 9:30 AM. 10/5/23 approximately10:25 AM - E2 (DON) confirmed there was no order for oxygen tubing to be changed and that R67's oxygen use was not referenced on care plan. Findings were reviewed with E19 (NHA), E1 (NHA in training), E2 (DON) and E3 (Unit Manager) at the exit conference on 10/6/23 at 1:55 PM.	F 695	Corrective measures for residents affected: R67 had oxygen in place. Comprehensive care plan reviewed and updated to reflect use of oxygen by unit manager. Oxygen tubing changed and dated accordingly by unit manager immediately. Identification of others with the potential to be affected: All residents that have require oxygen orders have the potential to be affected. Unit Manager, or designee, will complete an audit of all residents requiring oxygen usage to ensure care plans reflect usage and direct observation for dated oxygen tubing changes (Exhibit 5). Measures to prevent recurrence: Root cause analysis revealed residents care plan did not relfect oxygen usage and oxygen tubing was not properly dated. Staff educator or designee provided education to licensed staff to replace oxygen tubing with proper date weekly during evening shift. Unit manager or designee to update comprehensive care plans with new physician orders related to oxygen usage (Exhibit 20). Monitoring of corrective measures:	

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F 695	Continued From page 26	F 695	Director of Nurses, or designee, will complete audit to review physician orders report and comprehensive care plan, including direct observation for weekly dated tubing changes daily for 5 days, then 3 times per week for 3 weeks, and monthly for 3 months until 100 % compliance is achieved. Audit results to be forwarded to the Facility QAPI Committee (Exhibit 21).	
F 756 SS=C	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified	F 756		11/27/23

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F 756	Continued From page 27 irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to develop policies and procedures for the monthly MRR (Medication Regimen Reviews) that included time frames for different steps in the MRR process. Findings include: 10/4/23 - A review of the undated facility's policy titled "Medication regimen review and reporting" lacked information of the facility's time frame to respond to the pharmacy recommendations based on identified irregularities. 10/5/23 10:01 AM - An interview with E2 (DON), who stated that the facility completes a Monthly Medication Review (MRR) for each resident. The pharmacy will submit the recommendations and the MD will review it. E2 reviewed the policy and confirmed that the policy lacked information on timeframes for the steps of the MRR process. 10/6/23 - Findings were reviewed with E19 (NHA), E1 (NHA in training), E2 (DON), E3 (Unit Manager) on 10/6/23 at 1:55 PM.	F 756	Corrective Measures for residents affected: Administrator, DON and ADON updated facility policy for Medication Review and Reporting to reflect timeframes for acting upon pharmacy recommendations for the MRR process (Exhibit 24). Identification of others with the potential to be affected: All residents who require medications and have changes recommended by pharmacy have the potential to be affected. Measures to prevent recurrence: Root cause analysis revealed facility did not have a policy in which depicted appropriate MMR timeframes to be completed. Facility policy updated to reflect timeframe for MRR process	

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F 756	Continued From page 28	F 756	(Exhibit 24). A record of the Consultant Pharmacist's observations and recommendations is made available in an easily retrievable format to nurses, physicians, and care planning team within 48 hours of MMR completion. Licensed staff follows up on the recommendations to verify that appropriate action has been taken. Recommendations shall be acted upon within 30 calendar days (Exhibit 24). Education provided to clinical managers reflecting updated MRR policy, pharmacy to with review (Exhibit 25). Monitoring of corrective measures: Director of Nurses, or designee, to review pharmacy recommendations (MMR) daily for 5 days, then 3 times a week for 3 weeks, and monthly within 2 weeks of receiving MMRs for 3 months until 100% compliance is achieved (Exhibit 26). Audit results to be forwarded to the Facility QAPI Committee.	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and	F 761		11/27/23

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F 761	Continued From page 29 Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that one medication room out of one medication reviewed the facility failed to maintain medications narcotics under a double locks for one out of one medication rooms. In addition, the facility failed to monitor refrigerator temperatures. Findings include: 10/5/23 10:05 AM - The following was reviewed in the med room: - The refrigerator narcotic box containing six vials of lorazepam (medication to treat seizures and anxiety) was not secured to the fridge and was unlocked. - Review of the September 2023 temperature log for the medication refrigerator revealed that four out of thirty days: 9/1/23, 9/9/23, 9/14/23 and 9/15/23 morning shifts were missing temperature and staff initials. 10/5/23 10:53 AM - During an interview, E2	F 761	Corrective measures for residents affected: Narcotic locked boxes inside refrigerator on each station were permanently affixed by maintenance director to inside of securely locked refrigerator. DON or designee to complete daily monitoring of refrigerator temperature logs. Direct observation that narcotic boxes are affixed and locked. Identification of others with the potential to be affected: No residents were affected by this deficiency. Measures to prevent recurrence: Root cause analysis revealed temperature logs not completed and narcotic lock boxes not permanently affixed and locked	

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F 761	Continued From page 30 (DON) and E6 (UM) confirmed that the specified dates, times and initials were not documented on the temperature log and the narcotic box was unsecured. Findings were reviewed with E19 (NHA), E1 (NHA in training), E2 (DON) and E3 (Unit Manager) at the exit conference on 10/6/23 at 1:55 PM.	F 761	within locked refrigerator. Facility unable to correct missing temperature documentation. Staff educator or designee provided education to licensed staff to complete temperature logs daily and assure refrigerated narcotic locked boxes are locked and permanently affixed within station refrigerators (Exhibit 22). Monitoring of corrective measures: Director of Nurses, or designee, to review refrigerator daily temperature logs and locked boxes daily for 5 days, then 3 times a week for 3 weeks, and monthly for 3 weeks until 100% compliance is achieved. Audit results to be forwarded to the Facility QAPI Committee (Exhibit 23).	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and	F 812		11/27/23

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F 812	Continued From page 31 serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to maintain the correct concentration of sanitizing solution required to ensure proper sanitization of food preparation surfaces. Findings include: 9/29/23 10:47 AM- During a tour of the kitchen, E18 (Director of Food Services) tested the sanitizer level of the solution in a red sanitizing bucket. When E18 tested the sanitizing solution, the test strip indicated that the level of chemical concentration in the bucket was not sufficient to provide proper sanitization. Findings were reviewed with E19 (NHA), E1 (NHA in training), E2 (DON) and E3 (Unit Manager) at the exit conference on 10/6/23 at 1:55 PM.	F 812	Corrective measures for residents affected: Sanitizer level of solution found to be insufficient to PPM. DDS discarded and sanitizer prep redone and tested within sufficient PPM tested to provide proper sanitation. Identification of others with the potential to be affected: No negative outcomes to residents noted due to this deficiency. Measures to prevent recurrence: Root cause analysis revealed sanizer level outside appropriate PPM. DDS provide education to all dietary staff to drain and replenish sanitation solution to appropriate PPM (Parts per million) every 4 hours during open kitchen hours with initialed logbook maintained at sink. DDS or designee to monitor daily for compliance (Exhibit 29). Monitoring of corrective measures: Director of Dietary, or designee, to audit sanitation report and assure appropriate level of sanitation solution daily for 5 days, then 3 times a week for 3 weeks, and monthly for 3 months until 100% compliance achieved (Exhibit 30). Audit	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 32	F 812	results to be forwarded to the Facility QAPI Committee.	
F 814 SS=D	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility failed to ensure sanitary disposal of garbage. Findings include: 9/29/23 10:48 AM - During a tour of the kitchen, two large trash cans containg food waste and other kitchen debris were left uncovered with no lids available in the area. Findings were reviewed with E1 (NHA in training), E19 (NHA) on October 3, 2023 at 10:17 AM. Findings were reviewed with E19 (NHA), E1 (NHA in training), E2 (DON) and E3 (Unit Manager) at the exit conference on 10/6/23 at 1:55 PM.	F 814	Corrective measures for residents affected: Maintenance Director immediately removed trash cans without lids and replaced with new cans with matching fitted lids. Identification of others with the potential to be affected: No negative outcomes to residents noted due to this deficiency. Measures to prevent recurrence: Root cause analysis revealed trash cans were without proper covering during meal prep. DDS provided education to all dietary staff to assure trash can lids are available and are in place when not in immediate use (Exhibit 27). Monitoring of corrective measures: Director of Dietary, or designee, to complete direct observation audits for trash lids on cans when not in use daily for 5 days, then 3 times a week for 3	11/27/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085041	A. BUILDING _____ B. WING _____	C 10/06/2023

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F 814	Continued From page 33	F 814	weeks, and monthly for 3 months until 100% compliance is achieved (Exhibit 28). Audit results to be forwarded to the Facility QAPI Committee.	