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: Churchman Village **DATE SURVEY COMPLETED: August 17, 2022**

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 and Complaint Survey was conducted at this facility from August 4, 2022 through August 17, 2022. 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 87. The survey sample totaled 52 residents.	Please cross reference CMS 2567-POC submitted 9/8/2022 Cross refer to CMS 2567-L survey completed August 17, 2022: F550, F584, F625, F641, F656, F657, F676, F688, F697, F757, F759, F806, F812, F880, F887, F925 and F947.	
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 the following:** Cross refer to CMS 2567-L survey completed August 17, 2022: F550, F584, F625, F641, F656, F657, F676, F688, F697, F757, F759, F806, F812, F880, F887, F925 and F947.		
3201.6.0	**Services To Residents**		

Provider's Signature [signature] Title Executive Director Date 9/9/22

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3201.6.9	**Communicable Diseases**		
3201.6.9.1	**General Requirements**		
3201.6.9.1.1	**The facility shall follow Division of Public Health regulations for the Control of Communicable and Other Disease Conditions and Centers for Disease Control guidelines for communicable diseases.**		
3201.6.9.2	**Specific Requirements for Tuberculosis**		
3201.6.9.2.3	**The facility shall have on file the results of tuberculin testing performed on all newly placed residents.**		
3201.6.9.2.4	**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.** Based on interview and record review, it was determined that the facility failed to ensure that three (E12, E33, and E34) out of 10 employees reviewed, received the first step tuberculosis test prior to entering the facility or presented a chest x-ray for employment. Findings include: 8/15/22 – Review of the Employee Tuberculosis information documented on the facility's	1. The facility cannot go back retrospectively to complete pre-employment Tuberculosis test on employees E34, E12, E33.	

Provider's Signature ______________________ Title ______________ Date ____________

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	personnel spreadsheet revealed the following: 1. E34's (Cook) first day in the facility was 11/15/19. E34's results of the first PPD were documented as 8/28/20. 2. E12's (CNA) first day in the facility was 6/4/20. E12 submitted a chest x-ray documented as 3/1/21. 3. E33's (SSD) first day in the facility was 11/29/21. E33's results of the first PPD were documented as 12/6/21. During an interview on 8/17/22 at 9:35 AM, E5 (ICP) confirmed the above findings. Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 8/17/22, at approximately 2:00 PM.	2. A. All residents have the potential to be affected. B. All employee files will be audited to monitor that Tuberculosis testing are in accordance with the recommendations of the Centers for Disease and Control and Prevention and the Division of Public Health. Corrections will be made accordingly. 3. A. The RCA was determined that the facility was not following the current recommendations regarding Tuberculosis testing from the Centers for Disease and Control and Prevention and the Division of Public Health. B. The Staff Developer will educate the NHA on the current recommendations. C. HR will audit all new employees to determine if Tuberculosis testing complies with the current recommendations for the Centers for Disease and Control and Prevention and the Division of Public Health. 4. Audits will be presented in monthly QAPI meeting until 100% compliance is achieved for 3 months.	

Provider's Signature [signature] Title Executive Director Date 9/9/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085025	A. BUILDING ______ B. WING ______	C 08/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHURCHMAN VILLAGE	4949 OGLETOWN-STANTON ROAD NEWARK, DE 19713

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted at this facility from August 4, 2022 through August 17, 2022 by the State of Delaware Division of Health Care Quality, Office of Long Term Care Residents Protection in accordance with 42 CFR 483.73. The facility census on the first day of the survey was 87. For the Emergency Preparedness survey, all contracts, operation plans, contact information, and annual emergency drills were up to date. No deficiencies were identified.	E 000		
F 000	INITIAL COMMENTS An unannounced Annual and Complaint Survey was conducted at this facility from August 4, 2022 through August 17, 2022. 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 87. The survey sample totaled 52 residents. Abbreviations/definitions used in this report are as follows: ADL - Activity of Daily Living; ADON - Assistant Director of Nursing; BIMS (Brief Interview for Mental Status) - test to measure thinking ability with score ranges from 0 to 15. 13-15: Cognitively intact 8-12: Moderately impaired 0- 7: Severe impairment; CDC- Centers for Disease Control and Prevention;	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 09/08/2022

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 Cerebral Palsy-condition that affects muscle control and muscle movement CNA - Certified Nurse's Aide; Cochlear implant - two part hearing aide for people with severe hearing loss; DON - Director of Nursing; FSD - Food Service Director; ICP - Infection Control Preventionist; LPN - Licensed Practical Nurse; MDS (Minimum Data Set) - a standardized set of assessments completed in nursing homes; Nebulizer - a machine that produces a fine mist from a liquid that will be delivered to the lungs; NHA - Nursing Home Administrator; OT - Occupational Therapist; PA - Physician Assistant; RN - Registered Nurse; UM - Unit Manager; VPO - Vice President of Operations.	F 000		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including	F 583		10/10/22

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F 583	Continued From page 2 the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that for one (R3) out of one resident sampled for privacy, the facility failed to ensure that personal care and discussion of personal health information was provided in a way that promoted privacy. Findings include: Review of R3's clinical record revealed: 9/19/21 - R3 was admitted to the facility with chronic wounds to the lower legs and was provided services from a Wound Care Doctor. 8/11/22 11:33 AM - At the nurses station within hearing range of other residents and families, the Surveyor observed E28 (Wound Care Doctor) loudly saying he "had sent [R3] to the vascular doctor, he is non-compliant, that his wounds will never heal, and that he was going to lose his legs."	F 583	Once informed by the surveyor the wound doctor was re-educated on the need to discuss personal care information in a way that promotes dignity and privacy including drawing privacy curtain, shutting the door, and talking quietly at the nurse□s station when discussing resident care information. ADON will also be educated on the above. 2. All residents seen by the wound doctor and ADON have the potential to be affected. 3. A. The RCA was determined to be that the wound doctor and ADON did not realize their conversation regarding the care of the resident could be heard by others. B. Physicians/physician extenders associated with the facility will be re-educated on the need to discuss personal care information in a way that	

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F 583	Continued From page 3 8/11/22 1:20 PM - During an observation, it was noted that R3 was in his wheelchair in his room, approximately five feet from the door with dressings off of his legs exposing R3's multiple wounds. E28 (Wound Care Doctor) and E27 (ADON) were present in R3's room. The curtain and the door were left open and R3's treatment could be seen from the hallway. E28 spoke in a loud voice to R3 with R3's curtain and door open to the hallway. E28 stated that R3's non-compliance with care and if R3 did not accept treatment from the facility, then he was going to lose his legs. After some discussion between E27 (ADON) and E28 regarding R3's treatment, E27 and E28 exited R3's room into the hallway. E28 aggressively removed his surgical gown and stated, "I can't do this anymore. There is nothing that I can do." E27 inquired about what kind of treatment (dressings) to apply to R3's legs and E28 replied loudly, "Put whatever treatment on them (R3's legs) that he will allow." During the entire assessment the door and curtain were open to the hallway. The resident was visible to others and the discussion of his care could be heard by others. R3's legs and wounds were extremely red from R3's knees down to R3's toes and leaking fluid onto the floor. E27 and E28 proceeded to walk up the hall, did not apply dressings to R3's legs, and left the door open. 8/12/22 approximately 10:30 AM - During an interview, E27 (ADON) confirmed that R3's care was loudly discussed by herself and E28 (Wound Care Doctor) at the nurses station and with the door fully open to his room. Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 8/17/22, at	F 583	promotes dignity and privacy including drawing privacy curtain, shutting the door and talking quietly at the nurse□s station when discussing resident care information. C. The DON/designee will do weekly audits during wound rounds to monitor that the resident□s dignity, and privacy is maintained including drawing the privacy curtain, shutting the door, talking quietly at the nurse□s station when discussing resident care information. 4. The results of audits will be presented in the facility□s monthly QAPI meeting until 100% compliance is achieved for 3 months.	

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F 583	Continued From page 4 approximately 2:00 PM.	F 583		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1,	F 584		10/10/22

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F 584	Continued From page 5 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that for one (R69) randomly selected resident room for a safe, clean comfortable, home like environment, the facility failed to provide a safe, clean, comfortable, homelike environment. Findings include: 8/10/22 12:35 PM - FM1 (family member) requested the Surveyor to visit R69's room. 8/10/22 12:40 PM - During an interview with FM1, the following concerns were expressed by FM1 and observed by the Surveyor: - Approximately 40-50 fruit flies flew up from the cracked and soiled fall mat on the right side of the bed. The fruit flies encircled FM1 and the Surveyor. There were also fruit flies circling R69's uncovered lunch tray. - The area surrounding R69's bed, on the floor, had soiled dried food and debris. Under the bed was a used plastic cup and a medicine cup. On the floor between the bed and the bedside table there was a soiled washcloth. - The wall on both sides of the air conditioner approximately eight inches from the floor and towards the right and left corners of R69's room were stained and black. To the immediate right of the air conditioner, the wall was bowed out in an area approximately 2-3 inches in length exposing	F 584	The facility cleaned R69's room, replaced her air conditioner and fall matt, along with repairing the wall. 2. A. All residents who have anxiety and will not come out of the room have the potential to be affected. B. A whole house audit of resident's rooms will be conducted to assess the condition of the air conditioners, walls, fall matts along with checking for the presence of fruit flies. All corrections will be made accordingly. 3. A. The RCA was determined to be that a deep cleaning of the resident's room could not be completed due to the resident's anxiety and hesitance about coming out of her room along with nursing placing the bed on top of the fall mat preventing a deep cleaning of the floor. B. The Staff Developer will educate I staff will receive Behavior Health Training to include interpersonal communication and person-centered care when dealing with a resident with anxiety. C. Licensed Nurses, C.N.A.'s, Therapist, housekeepers will be educated on not placing the bed on the top of fall mats. D. NHA/designee will audit 10% of rooms weekly for condition of air conditioner, walls, fall matts and presence of fruit flies. 4. The results of audits will be presented in the facility's monthly QAPI meeting until	

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F 584	Continued From page 6 a blackened wooden board and a black area behind the drywall. - A bedside commode to the left of R69's bed had dark yellow foul smelling urine in it. During the observation, FM1 revealed that the condition of R69's room was brought to the nurses attention multiple times. It was further revealed that FM1 was told that the facility would deep clean R69's room, but it was never done. FM1 stated that R69 does not get out of bed because it is not comfortable and R69 becomes anxious. 8/10/22 at approximately 12:50 PM - During an observation and interview E6 (LPN), E10 (Maintenance Director) and E11 (Housekeeping Manager) confirmed the abovementioned condition of R69's room. On 8/10/22 at approximately 1:00 PM, an additional Surveyor confirmed the following: - In the area where the fall mat used to be, the floor was visibly dirty and bugs were swarming at the residue. - The area by the window had a black discolored wall. 8/10/22 1:16 PM - During an interview, E1 (NHA) confirmed the room required "attention" and stated that Maintenance and Housekeeping were in the room to address the concerns. 8/10/22 1:52 PM - During an observation and interview with E10 (Maintenance Director) and	F 584	100% compliance is achieved for 3 months.	

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F 584	Continued From page 7 E11 (Housekeeping Manager) in R69's room, E10 had removed the air conditioner, all of the molding the length of the left side of the bed and was removing the black stained drywall from the wall around the air conditioner. During the observation and interview E11 stated that Housekeeping personnel were not allowed to move the fall mats or R69's bed when she was in it, because it was a safety issue for R69. Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 8/17/22, at approximately 2:00 PM.	F 584		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At	F 625		10/10/22

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F 625	Continued From page 8 the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for two (R56 and R60) out of four residents reviewed for hospitalization, the facility failed to provide each resident and/or resident representative with a bed hold notice. Findings include: 1. R56's clinical record revealed: 4/16/22 to 4/22/22 - R56 was hospitalized. 4/26/22 to 4/28/22 - R56 was hospitalized. The facility lacked evidence that R56 and/or the resident's representative was provided a bed hold notice each time the resident was hospitalized in April 2022. 8/10/22 at 10:50 AM - During an interview, E3 (VPO) confirmed the finding. 2. R60's clinical record revealed: 7/7/22 to 7/20/22 - R60 was hospitalized. The facility lacked evidence that R60 and/or the resident's representative was provided a bed hold notice when the resident was hospitalized in July 2022. 8/10/22 at 10:50 AM - During an interview, E3	F 625	The New Admission Director was educated on the bed hold policy. The facility cannot go back retrospectively to issue bed hold letters to R56 and R60. 2. A. All residents that go to the hospital have the potential to be affected. B. All residents that are currently in the hospital will have their charts audited for proper bed hold notification. Bed Hold letters will be issued accordingly. 3. A. The RCA was determined be that the new Admission Director was not aware of the facility's bed hold policy. B. The NHA will educate the Admission Director and Business Officer Manager on the facility' Bed Hold policy. B. The NHA/designee will conduct weekly audits of all residents that were sent to the hospital to determine if a bed hold letter was given as per facility's policy. 4. The results of audits will be presented in the facility's monthly QAPI meeting until 100% compliance is achieved for 3 months.	

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F 625	Continued From page 9 (VPO) confirmed the finding. 8/17/22 at approximately 2:00 PM - Finding was reviewed during the exit conference with E1 (NHA) and E2 (DON).	F 625		
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.	F 656		10/10/22

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	035025	A. BUILDING ______ B. WING ______	C 08/17/2022

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F 656	Continued From page 10 (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. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that for one (R234) out of four residents reviewed for communication, the facility failed to develop a comprehensive person centered care plan for communication for R234. The communication care plan did not specify R234's ability to communicate and did not specify how R234 preferred to communicate. For two (R70 and R236) out of ten residents reviewed for ADL's, the facility failed to develop a care plan to address R236's toileting needs. Additionally, R70's care plan lacked staff assistance for R70's evening oral care. Findings include: 1. Review of R234's clinical record revealed: 7/23/22 - R234 was admitted to the facility with multiple diagnoses including bilateral unspecified hearing loss and intellectual disability. 7/25/22 - An admission MDS assessment documented R234 as having moderate difficulty hearing. 7/25/22 - A baseline care plan completed for R234 documented for staff to ensure that adaptive equipment needed was provided and	F 656	A. R234's communication care plan was updated to include the resident's ability to communicate, and how she prefers to communicate. B. R236's ADL care plan was updated to include the resident's preference to use a urinal when in bed. C. R70's dental care plan was updated to include the intervention for staff assistance with evening dental care. 2. A. All residents have the potential to be affected. B. A whole house audit of communication care plans will be conducted to determine if they include the resident's ability to communicate and how they prefer to communicate. Corrections will be made accordingly. C. A whole house audit will be conducted of ADL care plans to determine if they include the resident's preference to use a urinal. Corrections will be made accordingly. D. A whole house audit will be conducted of Dental Care Plans of residents with a self-care deficit to determine if " staff assistance" is included as an intervention when appropriate. Corrections will be made accordingly 3. A. The RCA was determined to be	

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F 656 Continued From page 11

functional, hearing aide, communication board, reminder's and cue's, and support goal involvement encouragement.

8/5/22 - A care plan for communication problem was created with a goal to "restore communication losses." Interventions included to refer to audiology for hearing consult as ordered; Monitor document nonverbal indicators of discomfort distress and follow up as needed; OT/PT/Nurse to evaluate resident dexterity/ability to use communication board, writing, use computer or sign language as alternate communication to speech; Resident is able to communicate by (specify - no specification of communication was documented); and Resident prefers communicating by (specify- there was no specification documented).

During an interview on 8/9/22 at 11:25 AM, E2 (DON) confirmed the findings and stated, "Sorry about that, we did not complete this, just a complete oversight."

2. 7/26/22 - R236 was admitted to the facility with multiple diagnoses including a broken left ankle.

7/26/22 - R236's care plan for ADL's included interventions to provide one person assistance with bed mobility, two person assist with transfers, toileting, bathing and dressing, set up with meals, encourage independence with ADL care, but offer assistance as needed, and provide adaptive equipment as ordered. The care plan lacked interventions that specified R236's preference to use a urinal for toileting needs.

7/29/22 1:07 PM - A plan of care note documented, "Admission bowel and bladder

F 656

that licensed staff failed to follow the facility's Comprehensive Care Plan policy. B. The Staff Developer will re- educate licensed staff on the facility' Comprehensive Care Plans policy and the need to develop and implement a comprehensive person-centered care plan for every resident. Comprehensive person centered care plans include the resident's ability to communicate and their preferred method to communicate, the resident's preference to use a urinal , and for the staff to provide assistance to resident's for dental care when appropriate. C. Monthly the DON/designee will audit 20% of communication, ADL and dental care plans to monitor that they are comprehensive and person centered and that they include the resident's ability and their preference to communicate, the resident's preference to use a urinal, and to include staff assistance for dental care when appropriate.

4. The results of audits will be presented in the facility's monthly QAPI meeting until 100% compliance is achieved for 3 months.

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F 656	Continued From page 12 evaluation completed. He is continent of both and toilets with two person assist. Staff will assist him at his request." 8/2/22 - An admission MDS assessment documented R236 as being cognitively intact and requiring extensive assistance of one person for toileting and being occasionally incontinent of both bladder and bowel. During an interview on 8/4/22 at 11:36 AM, R236 expressed a preference for using a urinal when in bed. During an interview on 8/9/22 at 11:29 AM, E2 (DON) confirmed R236 did not have a care plan that addressed the residents toileting needs. E2 stated, "Because he is continent, he doesn't have a care plan. Every resident is able to express themselves and the staff would offer them a urinal. The staff should offer him to use it. If he didn't want to use it staff would help him to the bathroom." 3. Review of R70's clinical record revealed the following: 5/15/15 - R70 was admitted to the facility with a diagnosis of Cerebral Palsy. 6/3/22 - A care plan problem for R70 stated, "Resident has a self-care deficit related to a decrease in functional mobility, strength, balance, and endurance." Care plan interventions included "Encourage independence in ADL care, but to offer assistance as needed." 8/5/22 10:01 AM - An interview with R70 revealed that her evening toothbrushing routine is very	F 656		

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F 656	Continued From page 13 important to her because she wants her mouth as clean as possible during the overnight sleeping hours. R70 stated that her Cerebral Palsy limits her ability to thoroughly clean her teeth in the evenings, so she routinely asks for staff assistance to brush her teeth in the evenings. R70 stated that staff do not provide her the requested assistance, instead telling R70 that she can do the task independently. 8/8/22 4:00 PM - During an interview with E9 (RN) and E20 (RN) concerning R70's requests to have staff assistance to help R70 brush her teeth in the evenings, E9 stated that the toothbrushing assistance was detailed in R70's care plan, so the aides know to help the resident. Review of R70's care plan lacked staff assistance with toothbrushing. 8/17/22 at approximately 2:00 PM - Finding was reviewed during the exit conference with E1 (NHA) and E2 (DON).	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff.	F 657		10/10/22

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F 657	Continued From page 14 (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. (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 record review and interviews, it was determined that for one (R13) out of two residents reviewed for dental, the facility failed to revise the care plan to reflect current resident needs when R13 refused dental cleaning despite the dentist's recommendation. Additionally, for one (R7) out of four residents reviewed for pain management, the facility failed to monitor for effects of sedation from taking opioid medication. Findings include: 1. Review of R13's clinical record revealed the following: 5/14/20 - Resident was admitted to the facility. 3/29/22 - A dental exam note documented that R13 wanted her teeth extracted, but she did not want a cleaning. R13 was recommended to have a cleaning. 8/4/22 12:54 PM - In an interview, R13 told the Surveyor that she saw the dentist a few months	F 657	A. R13's care plan was revised to include refusals of dental cleanings. 2. A. All residents that refuse routine dental cleanings have the potential to be affected. B. All residents who refuse routine dental cleanings will have their care plans audited and revised accordingly. 3. A. The RCA was determined that licensed staff and C.N.A.'s were unaware that refusals need to be documented in and reflected in the plan of care. B. The Staff Developer will educate Licensed Nursing staff on the need to revise care plans when a resident refuses care. B. The Staff Developer will educate C.N.A.'s and nurses on the need to document refusals. C. The DON/designee will audit 20% of dental care plans monthly to monitor that refusals are reflected on care plans. 4. The results of audits will be presented in the facility's monthly QAPI meeting until	

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F 657	Continued From page 15 ago for a tooth extraction. R13 added that she did not want dental cleaning services. 8/7/22 - R13's Care plan for active dental infection, initiated on 3/30/22, indicated that the problem was resolved as of 8/7/22. 8/8/22 1:15 PM - During an interview, E6 (LPN) stated that R13 had a tooth extraction and was on antibiotic therapy for a dental abscess. E6 also stated that R13 was recommended by the dentist for dental cleaning, but R13 refused. E6 further commented, "I just asked resident (R13) again about the dental cleaning, but she refused." 8/9/22 10:45 AM - In an interview, E9 (RN UM) stated that R13 has a behavior of refusing dental cleanings and further confirmed that her dental care plan should have been revised to include the behavior of refusing dental cleanings. 8/9/22 11:44 AM - Findings were discussed with E2 (DON). Findings were reviewed with E1 (NHA) and E2 during the exit conference on 8/17/22 at approximately 2:00 PM.	F 657	100% compliance is achieved for 3 months.	
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	F 676		10/10/22

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F 676	Continued From page 16 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, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §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 record review, it was determined that for two (R70 and R236) out of two residents reviewed for assistance with ADL's, the facility failed to provide R236 with devices to assist the resident with toileting and for R70, the assistance to brush their teeth. Additionally, for one (R234) out of four residents reviewed for communication, the facility failed to provide an assistive device to maintain	F 676	1. A. R236 was provided with a urinal and staff was educated. B. R234 was provided with her communication board and her hearing aids were sent out to be repaired. C. R70 is now receiving assistance with her evening dental care and staff was educated. 2. A. All residents have the potential to be affected. B. A whole house audit will	

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the resident's communication. Findings include

Review of R236's clinical record revealed:

7/26/22 - R236 was admitted to the facility with multiple diagnoses including a broken left ankle.

7/26/22 - R236's care plan for ADL's included interventions to provide one person assistance with bed mobility, two person assist with transfers, toileting, bathing and dressing, set up with meals, encourage independence with ADL care, but offer assistance as needed, and provide adaptive equipment as ordered. The care plan lacked interventions that specified R236's preference to use a urinal for toileting needs.

7/29/22 1:07 PM - A plan of care note documented, "Admission bowel and bladder evaluation completed. He is continent of both and toilets with two person assist. Staff will assist him at his request."

8/2/22 - An admission MDS assessment documented R236 as being cognitively intact and requiring extensive assistance of one person for toileting and being occasionally incontinent of both bladder and bowel.

During an interview on 8/4/22 at 11:36 AM, R236 stated, "I sat in the bed over an hour waiting on a urinal." R236 was observed with a cast to the left leg and reported to the Surveyor that he preferred to use a urinal in bed. Observation of R236's room and bathroom revealed no urinals for R236 to use for toileting.

During an interview on 8/9/22 at 9:48 AM, E25 (CNA) was able to show the Surveyor two urinals

F 676

be completed to determine who needs a urinal. Urinals will be provided accordingly. B. A whole house audit of hearing aids will be conducted to check for functioning. Repairs will be made accordingly. C. A whole house audit for resident's communication devices will be conducted. Devices will be provided to residents as needed. D. A whole house audit of residents that have a self-care deficit will be conducted to determine if they need assistance with dental care. Care will be provided accordingly.
3. A. The RCA for R236 was determined that his care plan was not updated with his preference B. It was determined the RCA for R324's missing communication board was that her roommate was a hoarder and took her communication board. C. RCA for R270 was that her care plan was not updated.
D. Licensed Nursing staff will be re-educated by the Staff Developer on the need to provide residents with care and services in accordance with their comprehensive assessment. D. C.N.A.'s will be re-educated on the need to report to their supervisors when devices are missing. F. Licensed nursing staff will be educated to report to unit manager/supervisor when hearing aides are not functioning. G. DON/designee will audit 20% of communication, ADL,and dental care plans to monitor that they include the resident's ability and preference to communicate, their preference to use a urinal, or if staff assistance is needed for dental care. DON/designee will check functioning of

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F 676	Continued From page 18 in R236's room. When asked how the CNA's know which residents prefer a urinal and where that information was located, E25 stated she "ask's the resident and the nurse and checks the electronic record for instructions.' Review of R236's electronic record lacked documentaion of R236's preference to use a urinal. During an interview on 8/9/22 at 11:29 AM, E2 (DON) confirmed R236 did not have a care plan that addressed the residents toileting needs. E2 stated, "Because he is continent, he doesn't have a care plan. Every resident is able to express themselves and the staff would offer them a urinal. The staff should offer him to use it. If he didn't want to use it staff would help him to the bathroom." 2. Review of R234's clinical record revealed: 7/23/22 - R234 was admitted to the facility with multiple diagnoses, including bilateral unspecified hearing loss and intellectual disability. 7/23/22 9:09 PM - A physician note documented, "Multiple medical comorbidities including mental retardation and severe hearing loss." 7/25/22 - An admission MDS assessment documented R234 as having moderate difficulty hearing, hearing aide "no." 7/25/22 - A baseline care plan completed for R234 documented for staff to ensure that adaptive equipment that the resident needs is provided and functional, hearing aide communication board reminder cue support goal involvement encouragement.	F 676	hearing aids monthly and as needed 4. The results of audits will be presented in the facility's monthly QAPI meeting until 100% compliance is achieved for 3 months.	

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7/25/22 4:02 AM - A note in R234's clinical record documented, "Alert and oriented to person, place, time, with hearing impairment, able to communicate by reading with communication board and make needs known verbally."

8/4/22 1:45 PM - R234 was observed sitting in a geri-chair, hearing aide was on the bedside table. R234's communication board was at the bedside.

8/5/22 - A care plan for communication problem was created with a "goal to restore communication losses." Interventions included to refer to audiology for heating consult as ordered; Monitor document nonverbal indicators of discomfort distress and follow up as needed; OT/PT/Nurse to evaluate resident dexterity/ability to use communication board, writing, use computer or sign language as alternate communication to speech; and Refer to audiology as ordered.

8/5/22 10:26 AM - R234 was observed in bed, no hearing aides in, no communication board visible.

8/5/22 11:07 AM through 11:15 AM - R234 was observed in therapy no hearing aides observed in ear, no communication board observed being used.

8/8/22 12:41 PM - R234 was observed in geri-chair. The Surveyor asked E12 (CNA) assigned to R234 if the resident wore hearing aides. E12 stated, R234 "Doesn't have any, I think they were going to get them." E12 was unable to locate R234's communication board. When asked how E12 communicates with R234, E12 stated, "We talk, she can hear some."

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F 676	Continued From page 20 8/8/22 12:59 PM - E29 (COTA) was observed leaving R234's room, when asked how E29 communicates with R234, E29 stated, "I speak loudly communicate she can hear." R234 did not have hearing aides in, and no communication board was observed. 8/9/22 9:16 AM - E12 (CNA) stated, "I followed up on R234 and the nurse keeps the hearing aides so the resident should have them now. " E12 confirmed she was unaware of the location of communication board. 8/9/22 10:58 AM - R234's hearing aides were observed on the table. E30 (LPN) stated, "Her daughter said they are not working, I think the ADON is working on that." At 11:00 AM E30 then stated, "The group came and they said that one [hearing aide] is working". E30 then confirmed she was unaware of the location of R234's communication board. The the clinical record lacked evidence that R234 had a daughter. 8/9/22 12:31 PM - E31 (ST) was asked whether R234 needed the communication board and hearing aides to communicate with staff. E31 stated, "I can't answer that. The white board was taken by the group home when they replaced the hearing aides, then they took it back. R234 can hear within functional limits." 8/9/22 12:45 PM - E2 (DON) reported to the Surveyor that R234's communication board was located. E2 stated, "R234's roommate had it in her possession." 8/9/22 2:28 PM - A note in R234's clinical record documented, "Pt's (patient's) white erase board is within her reach along with dry erase marker."	F 676		

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F 676	Continued From page 21	F 676		

Review of the CNA task list lacked evidence of awareness to ensure resident had communication board.

3. Review of R70's clinical record revealed the following:

5/15/15 - R70 was admitted to the facility with a diagnosis of Cerebral Palsy.

6/3/22 - A care plan problem for R70 stated, "Resident has a self-care deficit related to a decrease in functional mobility, strength, balance, and endurance." Care plan interventions included "Encourage independence in ADL care, but to offer assistance as needed."

7/14/22 - R70's quarterly MDS assessment revealed a BIMS of 15 (Intact cognitive response/decisions consistent) and required one person physical assistance with personal hygiene.

July 2022 - The electronic documentation Survey Report revealed that R70 needed staff assistance with personal hygiene, including toothbrushing, that occurred seven out of thirty one evenings.

8/5/22 10:01 AM - An interview with R70 revealed that her evening toothbrushing routine is very important to her because she wants her mouth as clean as possible during the overnight sleeping hours. R70 stated that her Cerebral Palsy limits her ability to thoroughly clean her teeth in the evenings, so she routinely asks for staff assistance to brush her teeth in the evenings. R70 stated that staff do not provide her the

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F 676	Continued From page 22 requested assistance, instead telling R70 that she can do the task independently. 8/8/22 4:00 PM - During an interview with E9 (RN) and E20 (RN) concerning R70 s requests to have staff assistance to help R70 brush her teeth in the evenings, E9 stated that the toothbrushing assistance was detailed in R70's care plan, so the aides know to help the resident. Review of R70's care plan lacked staff assistance with toothbrushing. 8/8/22 4:15 PM - E20 (CNA) was interviewed about the extent of help E20 gives R70 with ADLs in the evening, including assisting R70 to brush her teeth. E20 stated that she provices assistance, including toothbrushing, each time she works with R70 in the evening. 8/9/22 9:09 AM - R70 was asked if she received staff assistance to brush her teeth last evening. R70 said that she did not receive staff assistance with toothbrushing last evening, even after requesting staff assistance. Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 8/17/22, at approximately 2:00 PM.	F 676		
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	F 688		10/10/22

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F 688	Continued From page 23	F 688		

§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:
Cross refer F656

Based on observations, interviews and record review, it was determined that for one (R27) out of one resident reviewed for ROM (Range of Motion), the facility failed to ensure that R27's palm guard was in place on her right hand to keep the fingers extended. Findings include:

Review of R27's clinical records revealed the following:

3/12/20 - R27 was admitted to the facility with diagnoses including muscle weakness affecting the dominant right side.

2/20/22 - A CNA flowsheet for R27's restorative Splint/Brace Assistance Program revealed an instruction for "CNA to ensure that palm guard is in place to R27's right hand. Remove for hygiene ...".

4/18/22 - An OT (Occupational Therapy) treatment note documented, " ...Therapeutic carrot fitted & donned to R (right) hand to facilitate functional position of R hand. Pt.

1. R27 palm guards are now being applied as per physician's order.
2. A. All residents with splints and palm guards have the potential to be affected.
3. A. The RCA was determined that the Staff did not follow the physician orders regarding R27's palm guards. A. The Staff Developer will educate the C.N.A.'s and licensed staff on the need to follow physician orders regarding splints and palm guards. B. The Staff Developer will educate C.N.A.'s to report refusals to licensed staff so they can follow up. C. The Staff Developer per will educate C.N.A.'s and licensed staff on the Stop and Watch alert in the EMR so refusals can be track on the dashboard. B. DON/designee will conduct weekly audits on all residents that have physician orders for splints or palm guards to determine if they are wearing them in accordance with the physician order.
4. The results of audits will be presented in the facility's monthly QAPI meeting until 100% compliance is achieved for 3 months

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F 688	Continued From page 24 (patient) tolerated therapeutic carrot for approximately 4 hours on this date." 4/18/22 - R27 was discharged from OT services as she had reached the highest practical level. R27's current level of function was good with consistent staff follow through. 7/20/22 - A care plan was initiated for R27's contracture of the right wrist with interventions including CNA to ensure that palm guard is in place to R27's right hand and to provide assistance with the application of devices to prevent the formation of contractures. 7/28/22 - R27 had a physician's order for CNA to ensure that palm guard is in place to R27's right hand, remove for hygiene, check skin and report changes in skin and to remove at bedtime. 8/5/22 3:34 PM - During an observation, R27's right hand was closed. Subsequent observations on 8/8/22 at 9:50 AM, 8/822 at 3:21 PM and 8/9/22 at 4:02 PM revealed that R27's right hand continued to be closed. 8/9/22 4:02 PM - E6 (LPN) entered R27's room to check R27's right hand and confirmed that R27 did not have the palm guard on her right hand. E6 asked R27 if her right hand was hurting to which R27 moaned in response to pain. 8/10/22 11:28 AM - Review of R27's July 2022 CNA flowsheet on restorative Splint/Brace Assistance Program documentation revealed that for 20 out of 43 opportunities, R27's splint assistance was documented as "Not Applicable."	F 688		

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F 688	Continued From page 25 8/10/22 11:45 AM - Review of a new OT evaluation and plan of treatment, dated 8/10/22, revealed that R27 has "Palm guard managed by nursing, at baseline Pt (patient) presents with decreased right shoulder and wrist ROM. OT services recommended for splint management to increase ROM in shoulder, wrist and hand decreasing risk for further contracture." 8/10/22 12:03 PM - During an interview, E7 (OT) stated that on R27's discharge from OT services on 4/18/22, R27 was recommended for continued use of the palm guard to be placed on her right hand for skin integrity, to keep her nails from digging into her skin and to help with some extension of her fingers. 8/10/22 3:24 PM - In an interview, E3 (VPO) confirmed that when CNAs marked the flowsheet as "Not Applicable", it meant it was not done. 8/11/22 12:17 PM - Review of R27's 8/1/22 through 8/10/22 CNA flowsheet on restorative Splint/Brace Assistance Program documentation revealed that for 7 out of 10 opportunities, R27's splint assistance was documented as "Not Applicable." Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 8/17/22, at approximately 2:00 PM.	F 688		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice,	F 697		10/10/22

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F 697	Continued From page 26 the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that for one (R40) out of three residents reviewed for pain, the facility failed to treat the residents pain to the extent possible by not providing R40's pain relief gel at the bedside per physicians orders. Findings include: The facility policy on pain management, last updated 4/1/20, indicated that "Pain is whatever a resident says it is...". Review of R40's clinical record revealed: 6/10/22 - R40 was admitted to the facility with multiple diagnoses, including compression fracture of the back, history of a broken foot and osteoarthritis. 6/11/22 - A care plan was created for R40 for pain related to thoracic [back] compression fracture with a goal to have pain controlled to a level that is comfortable and acceptable to the resident. Interventions included, administer pain medications as ordered, report and document complaint, reposition for comfort, and try non-pharmacological interventions. 6/16/22- An admission MDS assessment documented R40 as cognitively intact, receiving scheduled and as needed pain medication interventions for frequent pain of 10 out of 10, (on a scale of 0-10). 7/13/22 - An order was written for R40 to receive	F 697	1. R40'S physician's order to leave analgesic cream at bedside has been discontinued and the resident's pain scale remains at zero. 2. A. All resident's that have physician's order to leave analgesic cream at bedside have the potential to be affected. B. A whole house audit of residents who have physician's orders for analgesic creams will be reviewed to determine if they comply with the facility's standing operating procedures regarding bed side medications. Corrections will be made accordingly. 3. A. The RCA was determined the physician was not aware that the facility does not permit analgesic creams to be left a bedside. B. The Staff Developer will educate the physician/physician extenders w on the facility's procedures regarding ordering medications to be left at bed side. C. Monthly the DON/designee will audit 30% the physicians' orders for analgesic cream medications to monitor if they are in compliance with the facility's standing operating procedures regarding bed side medications. 4. The results of audits will be presented in the facility's monthly QAPI meeting until 100% compliance is achieved for 3 months	

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F 697	Continued From page 27	F 697		

a pain relief gel with the following instructions, "Apply to both shoulders topically every 4 hours as needed for shoulder pain unsupervised self-administration, please give patient tube, she may self-administer."

7/27/22 10:30 AM - A physician's note documented, "The patient presented with back pain and was diagnosed with a T9 thoracic compression fracture... The patient was seen and examined at bedside. The patient says that her shoulder pain is still present although generally improved following the injection several weeks ago. R40 says she has still not yet had [pain relief] gel put on her shoulders. She has not been able to get the tube of gel despite asking repeatedly...".

During an interview on 8/4/22 at 10:44 AM, R40 reported pain of a 4 out of 10 in the shoulders and stated, "I've been asking for my pain relief gel for my shoulder several weeks. They keep saying they are ordering it. I'm supposed to be able to keep it here." The Surveyor received permission to look in R40's bedside drawer and was unable to locate pain relief gel.

During an interview on 8/8/22 at 11:48 AM, R40 rated her pain as a 3 out of 10 and stated, "It mostly hurts when I have to pull myself, reposition, or go to therapy. I was just repositioning myself." When asked if R40 received her pain relief gel, R40 stated, "Nobody ever gives it to me."

8/8/22 11:51 AM - E12 (LPN) accompanied the Surveyor to the treatment cart and showed the Surveyor R40's pain relief gel. E12 was asked whether the resident could have it at the bedside.

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F 697	Continued From page 28 E12 stated "No." E12 and the Surveyor reviewed R40's medication orders on the computer attached to the medication cart, that indicated the resident could have the pain relief gel at the bedside. E12 then stated, "I will take it there now." E12 entered R40's room with the pain relief gel to place it at the bedside. Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 8/17/22, at approximately 2:00 PM.	F 697		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by:	F 757		10/10/22

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

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F 757	Continued From page 29 Based on record review and interview it was determined that for one (R7) out of six residents reviewed for unnecessary drugs, the facility failed to ensure adequate monitoring of a pain medication. Findings include: Review of R7's clinical record revealed the following: 9/15/21- R7 was admitted to the facility with multiple diagnoses, including broken right and left ribs and a broken breastbone. 9/15/21-10/21/21- Review of R7's Medication Administration Record revealed a pain medication order for Oxycodone 2.5 mg by mouth every four hours as needed. The medication order did not include instructions to monitor R7's level of sedation. 9/16/21 12:54 - A progress note from E32 (Physician's Assistant) stated that "Staff will monitor for sedation and hold Oxycodone." Oxycodone as needed was administered to R7 on 9/21/21, 9/25/21 and 10/3/21. Progress notes on those dates did not describe monitoring R7 for sedation. 8/8/22 3:29 PM - During an interview, E2 (DON) confirmed that the medication order for Oxycodone as needed did not contain instructions to monitor for the side effect and hold for sedation. Findings were reviewed with E1 (NHA) and E2 on 8/17/22, at approximately 2:00 PM.	F 757	.R7's physician's order for Oxycodone 2.5 mg by mouth every four hours has been modified to include "monitor level of sedation". 2. A. All residents that have Oxycodone ordered may be affected. B. A whole house audit of residents who have physician's ordered Oxycodone will be conducted to determine if the physician/physician extender wants special instructions such as ""monitor level of sedation" is included in the order. Corrections will be made accordingly. 3. A. The RCA was determined that the Physician Assistant was not aware that she needed to include "monitor level of sedation" in the instructions since monitoring for sedation and any change in condition is part of the nursing process. B. Staff Developer will educate Physicians/Physician extender to include special instructions such as "monitor level of sedation" when writing orders. . C. The DON/designee will conduct weekly audits to determine if all oxycodone medications include "monitor level of sedation" in the instructions. 4. The results of audits will be presented in the facility's monthly QAPI meeting until 100% compliance is achieved for 3 months	
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More	F 759		10/10/22

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F 759	Continued From page 30 CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observations, record review, and interview, it was determined that the facility failed to ensure that it was free of a medication error rate of 5% or greater. During a medication pass observation on 8/10/22, two medication errors out of twenty seven opportunities were identified, resulting in a medication error rate of 7.40%. Findings include: The facility's policy titled, Staff Administered Medication, with an effective date of 4/1/20, documented: "The majority of medications administered in the Nursing Home are in a pre-packaged system from an approved pharmacy. The medications are administered by staff members as indicated by State regulations." Review of R382's clinical record and observation revealed: 8/10/22- A physician's order for Budesonide Suspension 0.5 MG/2ML-2 ml inhale orally via nebulizer two times a day for breathing issues. 8/10/22- A physician's order for Arformoterol Tartrate Nebulization Solution 15 MCG/2ML-2 ml inhale orally via nebulizer two times a day for breathing issues. 8/10/22 10:30- During a random medication pass	F 759	A. E26 was no longer employed at the facility B. R328 is now receiving her medications as per physician's order. 2. Al residents receiving medications via nebulizer have the potential to be affected. 3. A. The RCA was determined to be that E26 did not follow the facility's Right of Administration policy. B. All licensed nurses will be re-educated by Staff Developer on the facility's Right of Administration policy. C. The Staff Developer/designee will conduct a competency on administering nebulizer treatments with licensed staff. C. Weekly the DON/Designee will conduct 1 medication competency to monitor that licensed staff are administering medications as per the facility Rights of Admin stration policy. Audits will be conducted on various shifts, times and days. 4. The results of audits will be presented in the facility's monthly QAPI meeting until 100% compliance is achieved for 3 months	

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F 759	Continued From page 31 observation, E26 (LPN) administered the above medications to R382 as a single nebulized medication treatment, rather than as two separate medications as ordered. 8/10/22 11:00- During an interview, E26 confirmed that the medications were mixed together and administered as a single nebulizer treatment. 8/10/22 11:30- During an interview, E6 (LPN) confirmed that the physician order for Budesonide Suspension 0.5 MG/2ML-2 ml and Arformoterol Tartrate Nebulization Solution 15 MCG/2ML-2 ml did not include directions that the medications should be mixed together prior to administration. Findings were reviewed with E1 (NHA) and E2 (DON) on 8/17/22, at approximately 2:00 PM.	F 759		
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, it was determined that the facility failed to adhere to a food preference for one (R56) resident observed during a random meal	F 806	1. A. Once informed by the surveyor the resident was offered R56 an alternative protein with less salt. B. R56's meal ticket was revised to clearly indicate that she	10/10/22

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHURCHMAN VILLAGE	4949 OGLETOWN-STANTON ROAD NEWARK, DE 19713

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 806	Continued From page 32 observation. Findings include: Review of R56's clinical record revealed the following: 1/5/22 - R56 was admitted to the facility. 3/4/22 - A Physician's Order for a pureed renal diet and that R56 may order off of the renal diet as the resident requested. 8/12/22 beginning at 12:45 PM - A random lunch meal observation was conducted and R56 verbalized that she was served what she thought was pureed ham. R56 stated that she was only eating a small amount due to the salt content and stated that she was not supposed to have ham or sausage. Review of R56's meal ticket stated no sausage or ham. 8/12/22 1:00 PM - An interview with E13 (Food Service Director) revealed that R56 was served either a pureed ham or sausage which she should not have been served. 8/16/22 01:55 PM - Findings were confirmed with E1 (NHA) and E2 (DON). 8/17/22 at approximately 2:00 PM - Finding was reviewed during the exit conference with E1 and E2.	F 806	dislikes ham and sausage. 2. A. All residents have that have dislikes have the potential to be affected. B. A whole house audit of meal tickets will be conducted to determine if dislikes are clearly marked. Corrections will be made accordingly. 3. A. The RCA was determined to be that R56's meal ticket was not clearly marked that she disliked ham and sausage. B. Food Service Director will re-educate dietary staff on how to input dislikes into the meal tracking system. C. Food Service Director will re-educate dietary staff on how to read meal tickets. C. Food Service Director/designee will conduct weekly audits on 10% of the census to audit meal trays for accuracy. Audits will be conducted during various mealtimes. 4. The results of audits will be presented in the facility's monthly QAPI meeting until 100% compliance is achieved for 3 months	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources	F 812		10/10/22

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F 812	Continued From page 33 approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and interview, it was determined that the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety. Findings include: 1. During the initial kitchen tour on 8/4/22 at 9:27 AM, 22 slices of uncovered watermelon were observed plated and placed onto trays in the walk-in refridgerator. E12 (FSD) immediately confirmed the finding and stated the watermelon was "sliced yesterday." 2. The following issues were observed during the second kitchen visit on 8/5/22 at approximately 10:30 AM: -The fume hood was dusty and greasy. -The walls and table surfaces by the stove area were not clean. Findings were reviewed and confirmed by E12	F 812	1. All foods are now properly covered, the hoods, walls, and table surfaces by the stove area have been cleaned. 2. All residents have the potential to be affected. 3. A. The RCA was determined that the hoods were not put into the maintenance tracking system for bi-annual cleaning. B. Food Service Director will re-educate dietary on their daily and weekly cleaning assignments. C. Food Service Director will re-educate dietary staff on labeling, dating, and properly storing food. D. Hood maintenance was placed into the maintenance tracking system for bi-annual cleaning. E. Food Service Director/designee will conduct weekly kitchen inspections to monitor for proper labeling, dating, and storing of food, sanitation including cooks' area, and general maintenance of equipment to include hoods.	

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F 812	Continued From page 34 (FSD) on 8/5/22, at approximately 11:00 AM. Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 8/17/22, at approximately 2:00 PM.	F 812	4. The results of audits will be presented in the facility's monthly QAPI meeting until 100% compliance is achieved for 3 months	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;	F 880		10/10/22

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F 880	Continued From page 35 (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and review of facility policy and procedure, it was determined that the facility failed to maintain an effective infection prevention and control program by:	F 880	1. A. E22 was re-educated on the need to wear gloves when providing care. B. E24 was re-educated on the proper use of wearing gloves. C. E11 was re-educated	

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F 880	Continued From page 36	F 880		

failing to wear the appropriate PPE (personal protective equipment - gloves) when providing direct care to residents in their rooms and cleaning a resident's room during an outbreak of COVID-19; failing to disinfect the glucometer between resident use; and failing to complete adequate hand hygiene during medication administration. Findings include:

1. Due to an outbreak of COVID-19, the facility implemented nursing staff to wear full PPE (N95 masks, gowns, eye protection and gloves).

Observations of facility staff on the nursing units on 8/16/22 revealed:

- at 8:42 AM, observed E22 (CNA) and E23 (OT) on each side of R238's bed lifting the sheets to reposition the resident. E22 was observed not wearing gloves during this care, while E23 was wearing gloves. Finding was immediately discussed and confirmed with E22 upon exiting R238's room.

- at 9:55 AM, observed E24 (Housekeeping) in R286's room wearing only a glove on his right hand and wiping around the sink while the ungloved left hand was holding a pink plastic container with toiletries. After removing the glove, E24 sanitized his hands before collecting clean linens from the cart in the hallway. E24 went back in the room without donning gloves and proceeded to put clean linens on B bed, touching the footboard of B bed, then lifting the mattress to tuck in the linens. E24 then turned around and picked up his sweeper and dustpan and proceeded to clean the floor, then walked over to A bed and pulled the privacy curtain without wearing gloves. Finding was immediately

on the facility policy for disinfecting glucometer between residents D. E26 is no longer works at the facility.
2. All residents have the potential to be affected.
3. A. The RCA was determined that the employees did not follow the facility's policy regarding, donning and doffing gloves, disinfecting a glucometer and hand washing procedure. B. The Staff Developer will re-educate all staff on the proper technique for donning and doffing PPE including gloves. C. The Staff Developer will re-educate all licensed staff on the facility's policy for disinfecting glucometer with a return demonstration. D. The Staff Developer will re-educate staff on the proper procedure for hand hygiene including a return demonstration. E. The DON/designee will do weekly audits on 5% of scheduled staff on rotating shifts to monitor proper donning and doffing of PPE, along with proper hand washing technique. F. The DON/Designee will conduct 1 medication competency weekly to monitor that licensed staff are disinfecting glucometer per facility policy. Audits will be conducted on various shifts and days.
4. Results of audits will be reviewed in monthly QAPI until 100% compliance is achieved for 3 months.

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F 880	Continued From page 37	F 880		

Continued From page 37
discussed and confirmed with E24 upon exiting R286's room.

The facility failed to ensure staff followed infection control practices when providing direct care to residents and cleaning a resident's room during an outbreak of COVID-19.

2. The facility policy on blood sampling (finger sticks), last updated September 2014, indicated that staff should "Always ensure that blood glucose meters intended for reuse are cleaned and disinfected between resident uses."

During medication observations on 8/5/22 the following was observed:

9:58 AM - E11 (LPN) performed hand hygiene [HH], removed a glucometer from a drawer of the medication cart, entered R19's room and obtained the residents blood sugar. E11 then performed HH, entered R234's room, obtained the residents blood sugar and performed HH, then exited the room. E11 did not disinfect the glucometer between resident uses.

10:03 AM - E11 (LPN) placed the glucometer in the medication cart drawer and locked the medication cart. E11 did not disinfect the glucometer.

10:06 AM - E11 (LPN) confirmed the findings and stated, "I grab them [disinfectant wipes] from the documentation cart [station]. I usually clean it between each use, but didn't." E11 then attempted to obtain a disinfectant wipe from the documentation station in the hall, but it was empty. E11 had no disinfectant wipes on the medication cart. E11 locked the medication cart,

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F 880	Continued From page 38 went to obtain disinfectant wipes at 10:08 AM, returned at 10:11 AM and cleaned the glucometer. 3. A CDC guideline for Hand Hygiene in Healthcare Settings (https://www.cdc.gov/handhygiene/providers/index.html), updated January 2021, recommends: ".... When cleaning hands with soap and water, wet hands first with water, and rub hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers. Rinse hands with water and use disposable towels to dry. Use towel to turn off the faucet." 8/10/22- During a random medication administration, E26's (LPN) handwashing times were observed to be 7 seconds and 12 seconds respectively, before and after medication administration. E26 then turned off the water with her bare hands after handwashing, thus contaminating her hands. Findings were reviewed with E1 (NHA) and E2 (DON) on 8/17/22, at approximately 2:00 PM.	F 880		
F 887 SS=D	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized;	F 887		10/10/22

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F 887	Continued From page 39 (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses; (v) The resident or resident representative, has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; Note: States that are not subject to the Interim Final Rule - 6 [CMS-3415-IFC], must comply with requirements of 483.80(d)(3)(v) that apply to staff under IFC-5 [CMS-3414-IFC] and (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident; or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and	F 887		

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F 887	Continued From page 40 (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R131) out of six residents reviewed for COVID-19 immunizations, the facility failed to provide evidence that R131 or her family received the current information regarding the additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine. In addition, the facility lacked evidence that R131 or her family had the opportunity to accept or refuse the COVID-19 vaccine. Findings include: Review of R131's clinical record revealed the following: 6/12/21 - R131 was admitted to the facility. 7/9/21 11:40 AM - A nurse progress note documented, "This writer informed this resident that she is eligible for her second dose of vaccine this morning. Resident has PNA (pneumonia) and continues on abt (antibiotic) Augmentin. Reached out to (doctor) if we should hold vaccine due to PNA, and ordered to continue to vaccinate resident at this time since she has been on abt	F 887	R131 is no longer a resident of the facility. 2. A. All residents that receive COVID 19 vaccines has the potential to be affected. B. A whole house audit will be conducted on residents who the facility administered COVID vaccine to monitor that consents were uploaded in the EMR. Missing consents will be uploaded into the EMR. 3. A. The RCA was determined to be that after obtaining consent from the resident to administer the COVID vaccine the consent was not scanned into her medical record. B. Staff Developer will educate medical supplies and unit clerks on the need to update consents need to be scanned into the resident's medical record D. DON/designee will conduct weekly audits of 100% resident's who received the COVID vaccine to monitor that consent was scanned into the resident's medical record. 4. The results of audits will be presented in the facility's monthly QAPI meeting until 100% compliance is achieved for 3	

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F 887	Continued From page 41 for so many days already and is not contraindicated. Will be vaccinated today with dose #2 and resident made aware." 7/9/21 4:00 PM - A nurse progress note documented that R131 received her COVID-19 vaccine in her right arm with no signs or symptoms of adverse reactions noted. 8/16/22 10:34 AM - During a closed record review, R131's clinical record revealed that the facility lacked evidence that R131 or her family received the current information regarding the additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine. In addition, the facility lacked evidence that R131 or her family had the opportunity to accept or refuse the COVID-19 vaccine. 8/17/22 10:20 AM - In an interview with E5 (ICP), it was confirmed that R131's signed consent form was not found in the paper chart. 8/17/22 11:15 AM - Findings were discussed with E2 (DON). Findings were reviewed with E1 (NHA) and E2 during the exit conference on 8/17/22 at approximately 2:00 PM.	F 887	months	
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, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on-	F 943		10/10/22

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F 943	Continued From page 42 §483.95(c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. §483.95(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property §483.95(c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure that required dementia management training was completed for one E14 (CNA) out of five CNA's reviewed for annual training's. Findings include: 8/15/22 - CNA'S E14, E15, E16, E17, and E18 were reviewed on the staff training and vaccination worksheet for compliance with required annual dementia training. E14's most recent dementia training was documented as 11/6/20 and corresponding transcripts documented the same date. During an interview on 8/15/22 at 1:36 PM, E5 (RN Staff Development Coordinator) confirmed the education dates provided on the staff training worksheet and corresponding education transcripts. Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 8/17/22, at approximately 2:00 PM.	F 943	1. E14's dementia training is now up to date. 2. A. All resident's that have dementia have the potential to be affected. B. A whole house audit of C.N.A.'s education plans will be conducted to determine if their annual dementia training is up to date. Corrections to the C.N.A.'s training requirements will be made accordingly. 3. A. the RCA was determined to be that the facility did not have an accurate tracking system to monitor education. B. The facility will develop and implement a training tracking system for monitor annual training requirements. C. DON/designee will conduct monthly audits on all C.N.A.'s training plans to determine if they are up to date with their dementia training requirements. 4. The results of audits will be presented in the facility's monthly QAPI meeting until 100% compliance is achieved for 3 months	