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: Gilpin Hall Nursing Home **DATE SURVEY COMPLETED:** December 14, 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. A Recertification and Complaint survey was conducted by Healthcare Management Solutions, LLC on behalf of the State of Delaware Department of Health and Social Services, Division of Healthcare Quality. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B. was conducted by the State of Delaware Division of Health Care Quality, Office of Long Term Care Residents Protection, which began on December 11, 2023 through December 14, 2023. The facility census on the first day of the survey was ninety-one (91). The survey sample size was thirty-six (36) 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:		

Provider's Signature _____ Title Administrator Date 1-4-2024

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	Cross Refer to the CMS 2567-L survey completed December 14, 2023: F600, F755 and F880.	Cross Refer to the CMS 2567-L survey completed December 14, 2023: F600, F755 and F880.	1/31/2024

Provider's Signature Joan D Banner Title Administrator Date 1-4-2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085047	A. BUILDING _____ B. WING _____	C 12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILPIN HALL	1101 GILPIN AVENUE WILMINGTON, DE 19806

(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 000	INITIAL COMMENTS A Recertification and Complaint survey was conducted by Healthcare Management Solutions, LLC on behalf of the State of Delaware Department of Health and Social Services, Division of Healthcare Quality. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B. Survey Dates: 12/11/23 - 12/14/23 Survey Census: 91 Sample Size: 36 Supplemental Residents: 0	F 000		
F 600 SS=E	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the facility failed to ensure one Resident (R)83 was free from sexual abuse from R68. The facility also failed to ensure R47 was free from resident physical abuse from R143.	F 600	Incident 1: A. Both R68 and R83 with dementia diagnosis. R68 and R83 were verbally redirected and both residents were	1/31/24

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

Electronically Signed | 01/04/2024

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 600	Continued From page 1 Additionally, the facility failed to ensure R81 was free from sexual abuse from R73. Finally, the facility failed to ensure R51 was protected from verbal abuse by Certified Nursing Assistant (CNA) 5. Findings include: Review of a policy provided by the facility titled "Resident Abuse Policy/Procedure," dated 2020, indicated ". . . Physical Abuse: Intentionally and unnecessarily inflicting pain, injury or degradation to a resident. This includes, but is not limited to hit, push, kick, slap, pinch, or sexually molest any resident. . ." 1. Review of R68's electronic medical record (EMR) titled "Admission Record," located under "Profile tab" indicated the resident was admitted to the facility on 09/28/22 with a diagnosis of a stroke. Review of R68's EMR titled annual "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 10/03/22 indicated the resident had a "Brief Interview for Mental Status (BIMS)" score of six out of 15 which revealed the resident was severely cognitively impaired. The assessment indicated the resident had behaviors not directed to others. The assessment indicated the resident had no impairments with upper and lower extremities and used a walker for ambulation. Review of R68's EMR titled "Care Plan" located under the "Care Plan" tab dated 10/15/23 indicated the resident had a behavior of becoming sexually inappropriate with female residents who were cognitively impaired. The goal	F 600	physically separated. A physical assessment was completed for R83 with no injuries noted. Resident was unable to recall incident. Emotional support provided. B. A review of all incident reports through 2023 was conducted to identify other instances of R68 with episodes of abuse/inappropriate touching. No other residents affected. R68 was placed on visual safety checks. R68 was assessed by psychiatric nurse practitioner, who prescribed a medication adjustment. C. Root Cause was identified as resident assessments completed were not comprehensive enough to include the potential for resident to resident abuse. A Behavior Assessment Tool was created (attachment F600-1) to identify residents with increased potential for exhibiting inappropriate/abusive behaviors. A policy and procedure was developed (attachment F600-2) on the administration and review of the Behavior Assessment Tool. All new and current residents will be assessed using this Behavior Assessment Tool. Residents will be assessed upon admission, and then Quarterly. Resident care plans will be updated based on assessment responses. Nursing Staff will be trained on the completion of the Assessment and new procedure. All direct caregivers will receive additional training on abuse and how to identify and report abusive tendencies. D. DON or designee will review all reports	

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F 600	Continued From page 2 was to redirect the resident if the resident displayed any inappropriate behaviors or verbalizations directed to other residents. Review of R68's EMR titled incident "Progress Notes," located under the "Prog (Progress) Notes" dated 10/22/23 indicated the resident was found with his right hand touching R83's groin area. R68 was immediately removed from R83. R83 was assessed and no injuries. R68 was evaluated by the psychiatric nurse practitioner on 10/23/23 and ordered a medication adjustment. Review of R83's EMR titled "Admission Record" located under the "Profile" tab indicated the resident was admitted to the facility on 11/14/22 with a diagnosis of unspecified dementia without behavioral disturbances. Review of R83's EMR titled quarterly "MDS" with an ARD of 08/21/23 indicated staff could not complete a "BIMS" score and determined the resident had short- and long-term memory problems. The assessment indicated the resident required extensive assistance of two staff for bed mobility and transfers. Review of R83's EMR titled incident "Progress Notes" located under the "Prog Note" tab, dated 10/22/23 indicated Licensed Practical Nurse (LPN) 2 observed R68 rubbing his right hand on R83's crotch and she immediately removed the female resident from R68. R83's "Care Plan" was updated on 10/23/23 which reflected the allegation of sexual abuse. The goal was for the resident not to suffer any emotional abuse from the incident.	F 600	of abuse/inappropriate behaviors weekly until there are 3 consecutive weeks with 100% compliance to ensure that the Behavior Assessment Tool has been completed, the clinical team has reviewed the incident and the care plan was revised and updated to prevent future occurrences. After that, DON or designee will review all reports of abuse/inappropriate behaviors monthly until there are 3 consecutive months with 100% compliance to ensure that the Behavior Assessment Tool has been completed, the clinical team has reviewed the incident and the care plan was revised and updated to prevent future occurrences. After 3 months with 100% compliance, the monitoring will be concluded. Results to be reported to QAPI. Incident 2: A. Both R47 and R143 with dementia. R47 and R143 were verbally redirected and physically separated. R47 received nursing care for skin tears received during incident. Emotional support provided to R47. B. A review of resident to resident incidents reviewed during R143's residency with no other residents being affected. C. Root Cause was identified as resident assessments completed were not comprehensive enough to include the potential for resident to resident abuse.	

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F 600	Continued From page 3 Review of a document provided by the facility titled "Incident Report" dated 10/23/23 indicated R68 was found by staff rubbing R83's groin area. The investigation revealed both residents were immediately separated. The physician and the residents' responsible parties were notified of the incident. The facility also reported the incident to the State Agency (SA). The police were notified but no action was taken. Review of a document provided by the facility titled "Incident Report" dated 10/27/23 The report indicated both R68 and R83 both had a diagnosis of dementia. According to the report, R68 spends most of his time in his room watching television and would ambulate to and from the dining room for meals. The report revealed R83 spends most of the day outside of the nursing station and in a wheelchair. The report indicated on 10/22/23, R68 entered the main dining room at approximately 4:00 PM, which was too early for the dinner meal. According to the report, the resident was escorted to the outside of the dining room, to sit and wait until dinner was scheduled at 5:00 PM. At approximately 4:00 PM, the nurse observed R68 with his hand rubbing the groin area of R83 and the nurse immediately told R68 to stop, and both were separated. The psychiatric nurse practitioner and the primary physician were notified along with residents' representative. The psychiatric nurse practitioner adjusted R68's antidepressant after this incident. There were no further incidents by R68 after this incident. During an interview on 12/12/23 at 10:55 AM, LPN 2 confirmed she was the staff member who observed R68 touching R83 and then separated. LPN 2 stated she observed R68 grabbing R83's crotch really hard and gripping his hand on her	F 600	Dementia diagnosis inhibits one's ability to effectively communicate which can lead to reactions of physical aggression. A Behavior Assessment Tool was created (attachment F600-1) to identify residents with increased potential for exhibiting inappropriate/abusive behaviors. A policy and procedure was developed (attachment F600-2) on the administration and review of the Behavior Assessment Tool. All new and current residents will be assessed using this Behavior Assessment Tool. Residents will be assessed upon admission, and then Quarterly. Resident care plans will be updated based on assessment responses. Nursing Staff will be trained on the completion of the Assessment and new procedure. All direct caregivers will receive additional training on abuse and how to identify and report abusive tendencies. D. DON or designee will review all reports of abuse/inappropriate behaviors weekly until there are 3 consecutive weeks with 100% compliance to ensure that the Behavior Assessment Tool has been completed, the clinical team has reviewed the incident and the care plan was revised and updated to prevent future occurrences. After that, DON or designee will review all reports of abuse/inappropriate behaviors monthly until there are 3 consecutive months with 100% compliance to ensure that the Behavior Assessment Tool has been completed, the clinical team has reviewed the incident and the care plan was revised and updated to prevent future	

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F 600	Continued From page 4 groin. LPN 2 stated she considered the actions of R68 against R83 as sexual abuse. During an interview on 12/12/23 at 11:12 AM, the Assistant Director of Nursing (ADON) was asked why a conclusion was not made at the end of her investigation of R68 and R83. ADON stated R68 had dementia and a head injury. The ADON stated R68 did not touch the groin of R83 but touched her legs and stomach. A request was made to observe the camera footage. The facility did not provide camera footage of this incident by the end of the survey. 2. Review of R47's EMR titled "Admission Record" located under the "Profile" tab indicated the resident was admitted to the facility on 09/01/21 with a diagnosis of dementia. Review of R47's EMR titled "Care Plan" located under the "Care Plan" tab dated 09/13/21 indicated the resident had impaired cognitive function. Review of R47's EMR titled quarterly "MDS" with an ARD of 05/20/22 indicated the resident had a "BIMS" score of six out of 15 which revealed the resident was severely cognitively impaired. The assessment indicated the resident required limited assistance of one staff for bed mobility and transfers. The assessment indicated the resident used both a walker, or a wheelchair for mobility. Review of R47's EMR titled incident "Progress Note" dated 07/25/22 indicated R47 received physical aggression from another resident. The progress note revealed the other resident (R143) lifted his walker and hit R47. R47 obtained two	F 600	occurrences. After 3 months with 100% compliance, the monitoring will be concluded. Results to be reported to QAPI. Incident 3: A. Both R81 and R73 have advanced dementia. Both residents were verbally redirected and physically separated. R81 was provided increased supervision in facility safety program (after breakfast until after dinner) daily until room was changed. R81 does not recall the incident. Emotional support provided. B. A review of all incident reports related to R73 through 2023 was conducted and no other residents affected. R73 was placed on visual safety checks. R73 was assessed by psychiatric nurse practitioner, who prescribed a medication adjustment. C. Root Cause was identified as resident assessments completed were not comprehensive enough to include the potential for resident to resident abuse. A Behavior Assessment Tool was created (attachment F600-1) to identify residents with increased potential for exhibiting inappropriate/abusive behaviors. A policy and procedure was also developed (attachment F600-2) on the administration and review of the Behavior Assessment Tool. All new and current residents will be assessed using this Behavior Assessment Tool. Residents will be assessed upon admission, and then Quarterly. Resident	

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F 600	Continued From page 5 skin tears on both the left and right hands. The progress note revealed the resident sustained a skin tear on his right hand which measured 2 cm (centimeters) x 0.2 cm. The progress note indicated R47 had a skin tear on his left arm about 0.5 cm x 0.2 cm. Dressings were applied. The nurse notified the resident's responsible party and the physician. Review of R143's EMR titled "Admission Record" located under the "Profile" tab indicated the resident was admitted to the facility 05/26/22 with a diagnosis of unspecified dementia without behavioral disturbances. Review of R143's EMR titled admission MDS with an ARD of 06/01/22 indicated the resident had a "BIMS" score of six out of 15 which revealed the resident was severely cognitively impaired. The assessment indicated the resident had no behavior that placed others at risk of harm. Review of R143's EMR titled "Care Plan" located under the "Care Plan" dated 06/24/2022 indicated the resident had the potential to become physically aggressive as evidenced by poking his cane into other residents' chests. Review of a document provided by the facility titled "Incident Report" dated 07/24/22 indicated R47 received physical aggression from R143, when R143 hit R47 with a walker and caused skin tears. The residents' representative and physician were notified of the incident. The report indicated R47 was provided treatment after the incident. Review of a document provided by the facility titled "Incident Report" dated 07/28/22 indicated R143 became physically aggressive with R47,	F 600	care plans will be updated based upon assessment responses. Nursing Staff will be trained on the completion of the Assessment and new procedure. All direct caregivers will receive additional training on abuse and how to identify and report abusive tendencies. D. DON or designee will review all reports of abuse/inappropriate behaviors weekly until there are 3 consecutive weeks with 100% compliance to ensure that the Behavior Assessment Tool has been completed, the clinical team has reviewed the incident and the care plan was revised and updated to prevent future occurrences. After that, DON or designee will review all reports of abuse/inappropriate behaviors monthly until there are 3 consecutive months with 100% compliance to ensure that the Behavior Assessment Tool has been completed, the clinical team has reviewed the incident and the care plan was revised and updated to prevent future occurrences. After 3 months with 100% compliance, the monitoring will be concluded. Results to be reported to QAPI. Incident 4: A. Employee CNA5 was immediately suspended pending outcome of investigation and ultimately terminated. R51 was provided emotional support. R51 did not recall the incident. B. A review of all grievances and incident	

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F 600	Continued From page 6 due to a hearing deficit. The report indicated R47 sustained bi-lateral skin tears after being hit with a walker held by R143. Both residents were evaluated. The physician and the residents' responsible parties were notified of the incident. The facility also reported the incident to the SA. The police were notified but no action was taken. During an interview on 12/13/23 at 2:24 PM, Certified Nursing Assistant (CNA) 9 stated she observed R143 hold his walker over R47 and hit him. CNA9 stated R47 attempted to defend himself and was yelling at R143. CNA 9 stated she remembered R47 was injured but could not remember if he bled after the altercation. CNA 9 stated she and a former CNA 14 separated the residents immediately. During an interview on 12/14/23 at 9:59 AM, the Administrator, Director of Nursing (DON) and ADON defined abuse as an allegation of mistreatment, physical and/or sexual abuse. The DON stated for R83, she was involved with inappropriate touching by R68. The DON stated for R47 and R143, stated both residents were involved in a resident to resident and the facility was required to report these allegations to the SA. 3. Review of R81's electronic medical record (EMR) titled "Admission Record," located under "Profile tab" indicated the resident was admitted to the facility on 08/24/22 with a diagnosis of dementia and anxiety. Review of R81's EMR titled quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 11/28/23 indicated the resident had a "Brief Interview for Mental Status (BIMS)	F 600	reports related to abuse/inappropriate behaviors of 2023 was completed to determine no other residents affected. C. Root cause of incident identified as established policies not followed. All direct caregivers will receive additional training on abuse, how to identify abusive tendencies and encouraged to report any concerning behaviors of staff, residents and families to supervisors/administration. D. DON or designee will review all incident reports/grievances of abuse/inappropriate behaviors weekly until there are 3 consecutive weeks with 100% compliance to ensure that the clinical team has reviewed the incident and appropriate actions were taken to prevent future occurrences. After that, DON or designee will review all reports of abuse/inappropriate behaviors monthly until there are 3 consecutive months with 100% compliance to ensure that the clinical team has reviewed the incident and appropriate actions were taken to prevent future occurrences. After 3 months with 100% compliance, the monitoring will be concluded. Results to be reported to QAPI.	

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F 600	Continued From page 7 score of 99 indicative of severe cognitive impairment. Review of R81's EMR titled "Care Plan" located under the "Care Plan" tab indicated the resident has dementia and anxiety and is dependent on staff for meeting emotional, intellectual, physical, and social needs due to cognitive deficits. R81 has a history of wandering into different rooms and staff have to redirect her. R81 attends the safety program so she can be monitored more closely during the day and evening. Review of R73's EMR titled "Admission Record," located under "Profile tab" indicated the resident was admitted to the facility on 11/06/21 with a diagnosis of dementia and major depressive disorder (MDD). Review of R73's EMR titled annual "MDS" with an ARD of 09/21/23, R73's BIMS score was four out of 15 indicating the resident was severely cognitively impaired. On 11/27/23 R73's BIMS score was 11 out of 15 indicating the resident was moderately cognitively impaired. Interview on 12/12/23 with the MDS Coordinator revealed that she felt the "MDS" was not accurate. The resident had become more cognitively impaired. She did not retest the resident. Interview on 12/12/23 with R73's daughter revealed that her father no longer can carry on a meaningful conversation. Review of R73's EMR titled "Care Plan" located under the "Care Plan" tab in the EMR indicated the resident had dementia and spent most of his	F 300		

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F 600	Continued From page 8	F 600		

time wheeling around the unit in his wheelchair. The resident was noted to have inappropriate sexual behaviors with staff during care. On 01/26/22, R73 grabbed the wrist of a therapist and wanted her to sit on his lap. R73 was referred to Psychiatric Services and the Psychiatric nurse practitioner increased his Zoloft (anti-depressant) from 50 milligrams (mg) to 75 mg.

Review of a document provided by the facility titled "Incident Report" dated 08/24/23 indicated R81 was found by staff rubbing R73 in the groin area. The investigation revealed both residents were immediately separated. The physician and the residents' responsible parties were notified of the incident. The facility also reported the incident to the State Agency (SA).

Review of a document provided by the facility titled "Incident Report" dated 08/24/23 indicated the facility's investigation. The report indicated that both residents have a diagnosis of dementia. Both residents are confused and were redirected after the incident. Both residents live on the same floor, but on a different wing. Video surveillance indicated that R73 wheeled up to R81 in the hallway and held her hand and then put her hand in his groin. R81 started rubbing R73's private parts.

Interview on 12/11/23 at 11:06 AM with the husband of R81 revealed "The gentleman next door to my wife had inappropriate behavior with her. The facility stated that the gentleman was seen on video to take his wife's hand and place it on his private area. My wife was moved to a different hall on the same floor. She is now in the safety program and can be monitored more closely. The safety program is on the first floor,

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F 600	Continued From page 9 and she is there until 8:00 PM. I am here every day from 7:00 AM until 2:00 PM." Interview on 12/12/23 at 1:24 PM with the Business Office Clerk (BOC) revealed "I had to go to the second floor to visit a resident, and as I was walking down the hallway, I could see R81 and R73 sitting very close together. As I approached, I realized that R81 was rubbing R73 over his pants in a personal area. I was so shocked that I yelled to an aid to maybe move these two along. I went back downstairs and reported the incident to the staff development coordinator. When we went back upstairs, the two residents had been moved." During an interview on 12/14/23 at 9:59 AM, the Administrator, DON, and the ADON defined abuse as an allegation of mistreatment physical and/or sexual abuse. The DON stated "R81and R73 were involved with inappropriate touching that was initiated by R73. The facility was required to report this incident to the SA." 4. Review of the EMR under the "Profile" tab revealed the "Face Sheet" indicated R51 was admitted to the facility on 12/05/19 with a diagnosis of dementia. Review of the "MDS" located in the EMR under the "MDS" tab with an ARD of 11/07/23 revealed a "BIMS" score of three out of 15 indicating R51 was severely impaired cognitively. Review of the Facility Reported Incident (FRI) dated 10/20/23 provided by the facility revealed the verbal abuse was substantiated by the facility. The investigation revealed it was not noted R51 had a response at the time of the incident but no	F 600		

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reaction when asked again about how she felt about the incident and what she could recall. The facility interviewed staff and received witness statements. Per the FRI, CNA 5 was interviewed immediately after the incident by the Director of Nursing (DON) and was not allowed to come back to the facility after termination on 10/25/23.

Interview on 12/12/23 at 12:00 PM with the AD stated she came into help with dinner and heard CNA 5 yell "sit down" then said, "I said sit down." The AD stated she heard R51 ask "why are you yelling at me" and CNA5 said because you don't listen. The AD stated R51 seemed distraught. The AD stated another CNA came in and CNA5 stated for the CNA to take R51 out because she wasn't dealing with or couldn't handle this. The other aide removed R51, and the AD and nurse went to assess the resident. The AD stated she immediately reported the incident to DON. The AD stated R51 did not have any recollection of the event.

Interview on 12/12/23 at 12:05 PM with the DON stated she went up to talk to R51 later in the afternoon and R51 didn't remember and did have some confusion due to diagnosis. The DON stated CNA 5 was interviewed immediately and sent home. The DON stated CNA 5 denied yelling at R51. The DON stated CNA 5 was terminated immediately for verbal abuse after the investigation was complete.

Interview attempt on 12/12/23 at 1:08 PM with R51 confirmed the resident was severely impaired and could recall the event.

Interview on 12/14/23 at 11:56 AM with the Administrator revealed her expectations were for

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F 600	Continued From page 11 the staff to speak to the residents in a gentle tone. She stated abuse of any kind is not tolerated. The Administrator confirmed all staff, including agency staff were educated annually on abuse, and as needed.	F 600		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs	F 755		1/31/24

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F 755	Continued From page 12 is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and policy review, the facility failed to ensure one resident (Resident (R) 32) out of the 36 sampled residents received their medication at the ordered time by the physician. Findings include: Review of R32's "Admission Record" located in the "Admission" tab of the electronic medical record (EMR) revealed the latest admission date of 11/04/23 with diagnoses including Parkinsons and hypothyroidism. Record review of R32's quarterly "Minimum Data Set (MDS)" assessment located in the "MDS" tab of the EMR with an Assessment Reference Date (ARD) of 09/28/23 revealed a "Brief Interview of Mental Status (BIMS)" score of 14 out of 15 which indicated R32 was cognitively intact. Review of R32's "Care Plan" located in the "Care Plan" tab of the EMR, with a revised date of 02/20/20 revealed a problem was listed for hypothyroidism and an intervention was to administer medications as ordered. Review of R32's "Physician orders," located in the "Orders" tab of the EMR revealed an order for levothyroxine (for thyroid), carbidopa-levodopa (for Parkinsons), and omeprazole (for GERD). Review of R32's "Medication Administration Record (MAR)" for October 2022 revealed R32 did receive her medications that were due at 6:00 AM at 2:30 AM on 10/26/23.	F 755	A. Resident R32's Physician was notified immediately regarding medication administration time. An assessment of R32 was completed, there was no harm to resident. The agency who employed the nurse was notified of the incident. This agency nurse was placed on a "Do-Not-Return" list and is not allowed to work within the facility any longer. The State Licensing Agency and Board of Nursing were also immediately notified. B. All residents under the care of this nurse on that shift could have been affected by the actions of this nurse. Record review was immediately conducted for each resident under this nurse's care and reviewed with Medical Director. No resident was harmed by this nurse's actions. C. Root cause of incident identified as established policies not followed. A medication test for nursing staff was revised to include a question addressing correct medication administration times (attachment F755-1). All staff nurses must complete a medication test upon hire and as needed. Should an Agency (temporary)nurse be responsible for an assignment, they will also be required to complete and pass the medication test before administering any medications to residents within the facility. The Staff Development Coordinator or designee will review results of all medication tests for all	

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F 755	Continued From page 13 During an interview with R32 on 12/11/23 at 1:52 PM, it was revealed that an agency nurse had given her morning medications to her in the middle of the night. R32 called the nursing supervisor and told her about the incident. R32 revealed an investigation was done and she has not had it happen again. During an interview on 12/12/23 at 1:30 PM with the Director of Nursing (DON) confirmed the Nursing Supervisor relayed to her R32 had gotten her morning medications, which were due at 6:00 AM, in the middle of the night. The DON revealed she started an investigation and found out the incident had occurred on 10/26/22 and confirmed the resident's levothyroxine, carbidopa-levodopa, and omeprazole were due at 6:00 AM and were given at 2:30 AM. The physician were notified. The DON revealed R32 had been assessed with no adverse reactions. Record review of the "Medication Administration Procedure " policy with a revised date of 09/24/23 revealed the purpose of the policy was to ensure all medications were administered according to a physician's order and given at the right time.	F 755	nurses. Medication administration competencies will be issued randomly to nurses. D. A sampling of 3 nurses will be monitored daily through medication administration competencies to ensure medications are administered at the correct times. Once there are 3 consecutive days with 100% compliance, a sampling of 3 nurses will be monitored weekly to ensure medications are administered at the correct time. Once there are 3 consecutive weeks with 100% compliance, another sampling of 3 nurses will be monitored monthly to ensure medications are administed at the correct time. Once there are 3 consecutive months with 100% compliance, monitoring will be completed. Results will be reported to QAPI.	
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.	F 880		1/31/24

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F 880	Continued From page 14 §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; (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	F 880		

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F 880	Continued From page 15 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 observation, interview, record review, and facility policy review, the facility failed to ensure that one out of two residents (Resident (R) R24) observed during personal care were provided personal care in a manner that promoted infection control. Findings include: Review of R24's "Admission Record" under the "Admission" tab located in the electronic medical record (EMR) revealed the facility admitted R24 on 10/01/21. During an observation on 12/12/23 at 10:24 AM, revealed CNA12 was going to provide personal care to R24. CNA12 applied gloves, raised the bed, and removed the tab holding R24's brief in place. Observation further revealed R24 had had a bowel movement. CNA12 used a different wipe	F 880	A. CNA12 received additional training on performing perineal care of the female resident(Attachment F880-1). R24 clinical chart reviewed to indicate no incidents of infection from this practice. Room of R24 received a deep cleaning to include disinfection of all surfaces. B. Infection Control log reviewed for 2023. No other residents identified to have been affected by this practice. C. Root cause of incident identified as need for additional staff education and routine competency checks to ensure established policies are properly followed. Procedure of Perineal Care of the Female Resident amended to clearly state: "staff must change gloves after direct exposure to bodily fluids or fecal matter and	

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F 880	Continued From page 16 each time she cleaned the peri area and the bowel movement from the back side. CNA12 did not remove her gloves after cleaning the bowel movements. Observation further revealed CNA applied a cream to R24's peri area with the same gloves that were used to clean bowel movement. CNA12 took a wipe and cleaned the small amount of bowel movement and cream off the gloves on her hands. CNA12 taped the brief, took the pants off R24, and pulled the linens over the resident. CNA12 still had not changed her dirty gloves, which had been used to clean bowel movement. CNA12 lowered the bed with the remote, put the lid back on the cream, and then removed her gloves as she was leaving the room. CNA walked down the hall and washed her hands. During an interview on 12/12/23 at 10:40 AM CNA12 revealed she would remove the gloves if they were soiled but would keep them on otherwise until she was done with care. CNA12 asked this surveyor "should I change the gloves in between?" During an interview on 12/12/23 at 10:49 AM with the Director of Nursing (DON) revealed once the resident was cleaned then staff should remove their gloves, wash their hands, and put on clean gloves to apply brief and clothes. The DON revealed that was her expectations. The DON further revealed, "obviously it was an infection control issue if gloves were not changed from dirty to clean." The DON revealed if gloves were not changed it would contaminate clean things. The DON further revealed staff could wash their hands in each room since each room had a sink. Review of the facility policy titled, "Perineal Care	F 880	clean/disinfect hands prior to completing resident care and touching other clean surfaces (attachment F880-2). All nursing staff will receive training on procedure revision. Competency created within Relias for Perineal Care of the Female Resident to assess CNA's adherence to infection control procedures. D. The DON or designee will conduct 3 competency reviews for CNA providing perineal care for the female resident daily until 100% compliance for 3 consecutive days. After that, DON or designee will conduct 3 competency reviews for CNA providing perineal care for the female resident weekly until 100% compliance for 3 consecutive weeks. Once acheived, DON or designee will conduct 3 competency reviews for CNA providing perineal care for the female resident monthly until 100% compliance for 3 months. After 3 months with 100% compliance, the monitoring will be concluded. Results reported to QAPI.	

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F 880	Continued From page 17 of the Female Resident' with a reviewed date of 07/26/23 revealed gloves were to be applied before contact with the resident. Staff were to use a clean washcloth or cleaning cloth to clean the peri-anal area. The policy further revealed staff were to remove gloves and wash their hands before applying an incontinent product under the resident. Staff should apply gloves before repositioning the resident and finally wash their hands.	F 880		