

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

PRINTED: 03/01/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/04/2019
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NAME OF PROVIDER OR SUPPLIER HARBOR HEALTHCARE & REHAB CTR	STREET ADDRESS, CITY, STATE, ZIP CODE 301 OCEAN VIEW BLVD LEWES, DE 19958
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E 000	Initial Comments An unannounced annual and complaint survey was conducted at this facility from January 28, 2019 through February 4, 2019. The facility census the first day of the survey was 155 (one hundred fifty-five). During this period, an Emergency Preparedness survey was also conducted by the State of Delaware Division of Health Care Quality, Office of Long Term Care Residents Protection in accordance with 42 CFR 483.73. For the Emergency Preparedness survey, no deficiencies were cited.	E 000		
F 000	INITIAL COMMENTS An unannounced annual and complaint visit survey was conducted at this facility from January 28, 2019 through February 4, 2019. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census the first day of the survey was 155. The investigated sample size was 30. Abbreviations and Definitions used in this report are as follows: NHA - Nursing Home Administrator; DON - Director of Nursing; ADON - Assistant Director of Nursing; RN - Registered Nurse; LPN - Licensed Practical Nurse; MD - Medical Doctor; NP - Nurse Practitioner; RNAC - Registered Nurse Assessment Coordinator;	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 02/19/2019
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	<p>Continued From page 1</p> <p>CNA - Certified Nurse's Aide; SW - Social Worker; QA - Quality Assurance; UM - Unit Manager;</p> <p>ADLs (Activities of Daily Living) - tasks needed for daily living, e.g. dressing, hygiene, eating, toileting, bathing; ADL Self-Performance: - Extensive Assistance - resident involved in activity, staff provide weight-bearing support; - Limited Assistance - resident highly involved in activity, staff provide guided movement of limbs or other non-weight bearing assistance; - Supervision - oversight, encouragement or cueing; - Total Dependence - full staff performance every time activity performed; Antianxiety - medication to treat anxiety; Antidepressant - medication to treat depression; Antipsychotic - drug to treat psychosis and other mental/emotional conditions (e.g. Haldol); Anxiety- feeling worry, nervous or restless; CCD - Continuity of Care Document in facility electronic medical record; Cognition - mental processes or thinking; Cognitively Impaired - abnormal mental processes/thinking OR mental decline including losing the ability to understand, talk or write; Contracture - joint with fixed resistance to passive stretch of a muscle and cannot straighten; CPR - cardiopulmonary resuscitation; Dementia - brain disorder with memory loss, poor judgement, personality changes and disorientation OR loss of mental functions such as memory and reasoning that interferes with a person's daily functioning; DNR - Do Not Resuscitate; eMAR (electronic Medication Administration</p>	F 000		

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F 000	Continued From page 2 Record) - list of daily medications to be administered; eTAR (electronic treatment administration record) - list of daily treatments for each resident; GDR (Gradual Dose Reduction) - slowly reducing amount of medication; Hipsters - padded clothing worn by residents at risk for falls; Incontinence - loss of control of bladder and/or bowel function; Minimum Data Set (MDS) - standardized assessment forms used in nursing homes ; Milligram (mg) - metric unit of weight; Opioid - a strong narcotic pain medication that can be addictive; Palm protector - splint-type device to prevent hand contracture; PRN - as needed; Psychiatric - treatment of mental disorders ; Psychotropic (medication) - medication capable of affecting the mind, emotions and behavior ; Range of Motion (ROM) - extent to which a joint can be moved safely; R - right; X-ray - picture taken of bones or organs.	F 000			
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's	F 550		3/22/19	

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F 550	<p>Continued From page 3</p> <p>individuality. The facility must protect and promote the rights of the resident.</p> <p>§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.</p> <p>§483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.</p> <p>§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.</p> <p>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation it was determined that the facility failed to provide services in a manner that promoted respect for one (R96) out of three residents seated together for a meal on the Lewes unit. In addition, a derogatory label was verbalized during a random dining observation on the Lewes unit. Findings include:</p> <p>During random dining observations on the Lewes unit in the common area / assisted dining area:</p>	F 550	<p>A.) 1.) The center cannot retroactively go back and have R96's feeding assistance be provided at the same time as R133 and R29. 2.) Once informed of E8's statement Staff Developer educated staff on the Unit on terminology that promoted dignity.</p> <p>B.) All residents who require feeding assistance have the potential to be affected.</p>	

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F 550	Continued From page 4 1. 1/28/19 (8:35 PM 8:50 AM) - R96 was seated with R29 and R133 for breakfast. The meal had been served to R29, who was asleep, and R133, awaiting for assistance with eating. E16 (CNA) started to feed R133 while R96 looked in the direction of R133. R96's meal was served and s/he received assistance with eating approximately five minutes after R133 began being fed. 2. 2/4/19 (8:45 AM) - During breakfast observation E8 (RN) asked out loud "How many feeders are done there?" Findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) during the exit conference beginning at 4:00 PM.	F 550	C.) 1.) Staff Developer and /or designee will educate all clinical staff on feeding assistance procedures for set-up and service for Residents requiring feeding assistance. 2.) Staff Developer and/or designee will educate all staff on using terminology that promotes dignity. D.) 1.) NHA and / or designee will audit up to five (5) feeding assistance meal services (involving seating placement, timing, and terminology) week for a collective of twenty (20) observations a month; 20% of weekly audits will occur on weekends. 2.) Audits will be reviewed in monthly QA until 100% compliance is achieved for three (3) consecutive months.		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview it was determined that for one (R42) out of 30 sampled resident, the facility failed to ensure that the resident's call bell was within reach to ensure the resident's ability to utilize the call bell system. Findings include: 1/30/19 1:58 PM - R42 was overheard repeatedly calling, "Judy". Surveyor asked E18 (RN), "Who is Judy that R42 is calling for?" E18 replied that	F 558	A.) The center cannot retroactively make call bell be in reach during the three (3) observations. Once informed, the center verified that R42, R42's roommate and the entire unit had call bells available; education to resident's preference on location were provided, as needed. B.)1.) All residents have the potential to	3/22/19	

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F 558	<p>Continued From page 5</p> <p>he/she believes this is R42's daughter. An interview with R42 revealed that he/she believes that Judy is the name of his/her aide. It was observed that R42's call bell was not within reach and was on the floor towards the head of the bed. The surveyor handed call bell to R42 and reminded R42 to use it if he/she needed assistance.</p> <p>2/1/19 - approximately 12:55 PM - The call bell was observed to be on floor. An interview with R42 affirmed that he/she knows how to use the call bell, when questioned as to whether he/she knows how to use it. The surveyor retrieved the call bell from the floor behind bed and placed it in R42's hand. R42 stated, "I appreciate you doing that for me."</p> <p>2/4/19 9:47 AM - The surveyor overheard R42 calling out, "Help me." E18 was seen entering R42's room and then exiting. The call bell was observed on the floor towards the head of the bed. The surveyor returned call bell to R42 and again asked if R42 knew how to use it to call for assistance. R42 nodded and said, "yes."</p> <p>Based on the foregoing circumstances, it was determined that the facility failed to meet professional standards in the area of reasonable accommodations and ensure that the resident's call bell was within use to ensure the resident's ability to utilize the call bell system.</p> <p>Findings were reviewed with E1 (NHA), E2 (DON), and E3 (ADON) during the exit conference beginning on February 4, 2019 at approximately 4:00 PM.</p>	F 558	<p>be affected. 2.) A whole house audit was conducted that all call bells were available, proper length, and positioned for use in each room.</p> <p>C.)1.) Staff Developer / Designee will educate all staff on placement of call bells. 2.) Call Bell placement has been added to new QAPI Rounding tool.</p> <p>D.) 1.) NHA and / or designee will observe up three (3) rooms, one on each unit for random appropriate call bell placement. Twenty-one (21) observations will be made weekly, 20% or more of which will occur on weekends. 2.) Audits will be reviewed in monthly QA until 100% compliance is achieved for three (3) consecutive months.</p>		
F 622 SS=E	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii)	F 622		3/22/19	

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F 622	<p>Continued From page 6</p> <p>§483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.</p>	F 622		

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F 622	<p>Continued From page 7</p> <p>§483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.</p> <p>(i) Documentation in the resident's medical record must include:</p> <p>(A) The basis for the transfer per paragraph (c)(1)(i) of this section.</p> <p>(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).</p> <p>(ii) The documentation required by paragraph (c)(2)(i) of this section must be made by-</p> <p>(A) The resident's physician when transfer or discharge is necessary under paragraph (c)(1)(A) or (B) of this section; and</p> <p>(B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section.</p> <p>(iii) Information provided to the receiving provider must include a minimum of the following:</p> <p>(A) Contact information of the practitioner responsible for the care of the resident.</p> <p>(B) Resident representative information including contact information</p> <p>(C) Advance Directive information</p> <p>(D) All special instructions or precautions for ongoing care, as appropriate.</p> <p>(E) Comprehensive care plan goals;</p> <p>(F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and</p>	F 622		
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F 622	<p>Continued From page 8</p> <p>any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by:</p> <p>Based on records review and interview, it was determined that the facility failed to ensure information was provided to the receiving provider for four (R42, R64, R113, and R110) out of five sampled residents investigated for hospitalizations. The facility failed to include resident care plan goals in the transfer/discharge information. Findings include:</p> <p>The facility's "Transfer and Discharge Requirements Policy" dated October 9, 2017 revealed the following: "Nursing will complete the Resident Transfer Form and send the following documents with the resident at the time of transfer: Resident Transfer Form, CCD (Continuum of Care Document), Care Plan(s), and most recent labs/X-rays. Note: It may not be possible to convey all care plan information prior to urgent transfers, however, this information must be conveyed as close as possible to the actual time of transfer."</p> <p>The following residents were transferred from the facility and did not have evidence that the care plan goals were provided to the receiving provider:</p> <ol style="list-style-type: none"> 1. R42 was admitted to the hospital on November 1, 2018. 2. R64 was admitted to the hospital on November 9, 2018 and January 26, 2019. 3. R113 was admitted to the hospital on November 28, 2018 and January 13, 2019. 	F 622	<p>A.) The Center cannot retroactively provide R42, R64, R113, and R110 the care plan goals at time of their hospital transfer. Residents R42, R64, R113, and R110 will have their care plan goals sent to the medical office at the hospital. All four (4) residents returned to Harbor.</p> <p>B.) 1.) All residents transferred to the hospital have the potential to be affected. 2.) Residents transferred to the hospital since January 1, 2019 will have their care plan goals sent to the medical records office at the hospital.</p> <p>C.)1.) Root Cause Analysis discovered electronic medical record (EMR) hospital transfer documentations did not forward the care plan goals to the transfer paperwork. 2.) Effective, February 10, 2019, all care plan goals are now automatically part of the hospital transfer program. 3.) Staff Developer and / or designee will educate all clinical staff on the transfer documentation change and incorporate the change into new hire orientations.</p> <p>D.) DON and / or designees will monitor all hospital transfers to verify that care plan goals were sent for a period of four (4) weeks. 2.) Audits will be reviewed in monthly QA until 100% compliance is achieved for three (3) consecutive months.</p>		

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F 622	Continued From page 9 4. R110 was admitted to the hospital on December 23, 2018. 2/4/19 10:45 AM - Interview: E17 (RN, Staff Educator) stated that the facility does not send care plan goals to receiving providers during hospital transfers. E17 thought this requirement was just for discharges to home and other long term care facilities. 2/4/19 11:51 AM - Interview: E1 (NHA) confirmed that the facility does not send care plan goals to receiving providers during hospital transfers. E1 stated that they usually send transfer papers with care plan observations from the electronic medical record, but not the care plan goals. Based on the foregoing circumstances, it was determined that the facility failed to provide comprehensive care plan goals to another facility at the time of resident transfer. Findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) during the exit conference beginning on February 4, 2019 at approximately 4:00 PM.	F 622			
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or	F 623		3/22/19	

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F 623	<p>Continued From page 10</p> <p>discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and</p> <p>(iii) Include in the notice the items described in paragraph (c)(5) of this section.</p> <p>§483.15(c)(4) Timing of the notice.</p> <p>(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.</p> <p>(ii) Notice must be made as soon as practicable before transfer or discharge when-</p> <p>(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;</p> <p>(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;</p> <p>(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;</p> <p>(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or</p> <p>(E) A resident has not resided in the facility for 30 days.</p> <p>§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:</p> <p>(i) The reason for transfer or discharge;</p> <p>(ii) The effective date of transfer or discharge;</p> <p>(iii) The location to which the resident is transferred or discharged;</p> <p>(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how</p>	F 623		

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OMB NO. 0938-0391

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F 623	<p>Continued From page 11</p> <p>to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;</p> <p>(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;</p> <p>(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and</p> <p>(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.</p> <p>§483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.</p> <p>§483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).</p>	F 623		

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F 623	<p>Continued From page 12</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure information and notifications were provided to the resident / responsible party for one (R110) out of five sampled residents for hospitalization. The facility failed to provide discharge / transfer notice that included: reason; location; statement of appeal rights; and contact information for the Ombudsman and advocacy agencies as indicated to R110 (or responsible party). Findings included:</p> <p>The facility's "Notice of Transfer or Discharge" policy (dated October 9, 2017) stated that: Before the resident is transferred or discharged, social services or a designee will notify the resident and the resident's representative of the transfer or discharge and the reasons for the move in writing...the written notice must include: reason, date, location to which the resident is being transferred, statement of appeal rights, and contact information for the Ombudsman and advocacy agencies as indicated.</p> <p>Review of R34's clinical record revealed the following;</p> <p>12/20/18 - Progress Note: R110 was sent from an outpatient physician office visit to the emergency department and was admitted to the hospital for low blood pressure, but the clinical record provided no evidence that R110 or R110's representative were notified in writing of the facility discharge and provided the required notices.</p> <p>1/31/19 12:55 PM - During an interview, E10 (Admissions Director) stated that the facility does not have a copy of a letter or any documentation</p>	F 623	<p>A.) Center cannot retroactively provide the written discharge/ transfer information to R110 at the time of transfer to the hospital. R110 did return safely back to previous room upon discharge from the Hospital.</p> <p>B.) 1.) All residents who transfer or discharge from an office visit or planned medical / social leave / appointment have the potential to be affected. 2.) All residents transferred to the hospital outside of the facility, since January 1,2019, will be audited for appropriate notice sent. Missing paperwork will be sent to the resident / responsible party.</p> <p>C.) 1.) RCA determined that there was no method of auditing residents who are sent to the hospital from an outside location. Notice of transfer / discharge sent from an outside location will be added to night shift supervisor checklist. 2.)Notification of notice to be sent for Center Transfer / Discharge paperwork will be sent to the resident / responsible party by Admissions Office and / or designee within twenty-four (24) hours of such transfer. 3.) NHA and Staff Developer will develop education for Admissions office and designees on this type of transfer documentation process. Monitoring will be added to weekend Manager On Duty rounding tool.</p> <p>D.) 1.) All future transfers originating from outside of the facility will be reviewed for</p>		

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F 623	Continued From page 13 to verify the required information was given to R110 or his responsible party. These findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) during the exit conference beginning at 4:00 PM.	F 623	Transfer and Discharge policy paperwork compliance by DON and / or designee on a weekly basis. 2.) Audits will be reviewed in monthly QA until 100% compliance is achieved for three (3) consecutive months.		
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 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	F 625	A.) Center cannot retroactively provide	3/22/19	

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F 625	<p>Continued From page 14</p> <p>determined that for one (R110) out of five sampled residents for hospitalization the facility failed to provide the bed-hold notice upon transfer to the hospital as required. Findings include:</p> <p>The facility's "Bed Hold and Return to Center" policy (last updated 4/20/18) stated that: A copy of the facility Bed Hold Policy Review and Notice will be provided to the residents and/or resident representative at the time of transfer or in cases of emergency transfer, within 24 hours. Multiple attempts to notify the resident representative will be documented in the progress notes in cases where the facility was unable to notify the representative.</p> <p>Review of R34's clinical record revealed the following:</p> <p>12/20/18 - Progress Note: R110 was sent from an outpatient physician office visit to the emergency department and was admitted to the hospital for low blood pressure, but there was no evidence that the written Bed Hold policy was provided to the resident or to the responsible party.</p> <p>1/31/19 12:55 PM - During an interview, E10 (Admissions Director) stated that the facility does not have a copy of a letter or any documentation to verify the required information was given to R110 or his responsible party.</p> <p>These findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) during the exit conference beginning at 4:00 PM.</p>	F 625	<p>the written Bed Hold Policy information to R110 at the time of transfer to the hospital. R110 did return safely back to previous room upon discharge from the Hospital.</p> <p>B.) 1.) All residents who transfer or discharge from an office visit or planned medical / social leave / appointment have the potential to be affected. 2.) All residents transferred to the hospital outside of the facility, since January 1,2019, will be audited for appropriate notice sent. Missing paperwork will be sent to the resident / responsible party.</p> <p>C.) 1.) RCA determined that there was no method of auditing residents who are sent to the hospital from an outside location. Notice of bed hold policy sent from a transfer from an outside location will be added to night shift supervisor checklist. 2.) Notification of bed hold policy paperwork will be sent to the resident / responsible party by Admissions Office and / or designee within twenty-four (24) hours of such transfer. 3.) NHA and Staff Developer will develop education for Admissions office and designees on this type of transfer documentation process. Monitoring will be added to weekend Manager On Duty rounding tool.</p> <p>D.) 1.) All future transfers originating from outside of the facility will be reviewed for Bed Hold policy paperwork compliance by DON and / or designee on a weekly basis. 2.) Audits will be reviewed in monthly QA until 100% compliance is achieved for three (3) consecutive</p>		

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F 625	Continued From page 15	F 625		
F 657 SS=D	<p>Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)</p> <p>§483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be-</p> <p>(i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined 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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interviews and record reviews, it was determined that the facility failed to revise the comprehensive person-centered care plan for two (R34 and R134) out of the 30 sampled residents. For R34 the facility failed to revise a care plan to reflect a designated time for splint application to R34's right hand. For R134</p>	F 657	<p>months.</p> <p>A.) 1.) R4's care plan has been revised to reflect the splint application times. 2.) R134's care plan has been updated to include self-feeding by placing utensils in his hands and discontinued use of psychotropic medication.</p>	3/22/19

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F 657	<p>Continued From page 16</p> <p>ADLs, psychotropic drug and eating preference care plans did not reflect current function / treatment. Findings include:</p> <p>1. Review of R34's clinical record revealed the following;</p> <p>3/26/18- [last reviewed 10/4/18] R34's care plan for ADL function and rehabilitation was updated to include the intervention to apply a hand splint to right upper extremity (hand) for two hours on/two hours off.</p> <p>3/29/18 - An order was written for R34 to wear a splint to his right hand on for two hours, then off two hours, followed by a skin check, laundry as needed, and resident may remove as needed.</p> <p>11/9/18 - A quarterly Minimum Data Set (MDS) assesment documented R34 as moderately impaired with memory problems, behaviors of rejection of care, and upper extremity impairment on one side.</p> <p>During an interview on 1/31/19 at 11:46 AM with E21 (LPN) it was reported that R34's splint was to be applied for two hours then removed for two hours, E21 confirmed that there was no specified time for application and stated "Its just off and on it doesn't specify any times". When asked how would CNA staff know when to apply the splint during the shift E21 stated "I don't know, I can ask them".</p> <p>During an interview on 1/31/19 at 11:50 AM with E22 (LPN) it was reported that R34's splint was to be applied every two hours on the even hour, beginning at 8:00 AM to 10:00 AM then off until 12:00 noon. E22 confirmed that this information was not documented anywhere in R34's clinical</p>	F 657	<p>B.) 1.) All Residents that wear splints have the potential to be affected. 2.) A whole house care plan audit on residents with splints will be conducted and adjustments made accordingly. 3.) Any residents that needs encouragement by staff to self feed has the potential to be affected. 4) A whole house care plan audit on residents that need encouragement to self feed will be conducted and adjustments made accordingly. 5.) Any residents that have a psychotropic medication discontinued can be affected. 6.) A whole house care plan audit on residents who have had psychotropic medication will be conducted and changes made accordingly.</p> <p>C.) 1.) RCA determined that electronic care plan notes did not always transfer preferences, schedules, and changes in medications in a method that best serves the C.N.A. assignment and the C.N.A. electronic menu for resident preferences and changes. 2.) Staff Developer will coordinate education for clinical and therapy staff on personalization care plans of dining preferences, splint device schedules, and discontinuation of psychotropic medication.</p> <p>D.) 1.) DON and / or designees will monitor all new splint devices orders for care plan personalization, review three (3) dining preference care plan reviews for residents per week for accuracy, and all new discontinuation of psychotropic medications to match care plans. 2.) Audits will be reviewed in monthly QA until 100% compliance is achieved for three (3) consecutive months.</p>		

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F 657	<p>Continued From page 17 record.</p> <p>During an interview on 1/31/19 at 11:57 AM with E8 (RN) unit manager for R34 it was confirmed that there was no documented time frame for splint application. E8 reported that "a nurse will tell them" the time for splint application.</p> <p>During an interview on 1/31/19 at 12:41 PM with E3 (ADON) it was reported that direct care staff would know when to apply R34's splint because it should be put on at the start of shift.</p> <p>During an interview on 1/31/19 at 3:44 PM with E23 (CNA) when asked what time R34's splint would next be applied, E23 stated "the nurse just told me that I need to put it on at 4:00 PM". E23 reported the prior to that day she would "usually ask the CNA whoever had them on the shift before otherwise I don't know and I just put it on."</p> <p>R34's care plan was not revised to reflect the splint application times.</p> <p>Cross Refer F676.</p> <p>2. Review of R134's clinical record revealed:</p> <p>a. 6/17/15 - The care plan for ADLs (revised 3/22/18) included the approach to set-up trays for meals, assist with feeding if needed, and monitor to ensure adequate intake of food and fluids.</p> <p>1/29/19 (8:47 AM) - Breakfast observation revealed R134 receptive to having the fork placed in his hand, which prompted the resident to begin self feeding.</p> <p>1/31/19 (12:25 PM) - Lunch observation found that the resident started to eat the meal after E25</p>	F 657			

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F 657	<p>Continued From page 18 (Activity Assistant) placed the fork in R134's hand.</p> <p>1/31/19 (12:45 PM) - Interview with E24 (CNA) revealed that R134 would become agitated and curse if staff physically attempts to feed the resident.</p> <p>2/1/19 (between 8:27 AM - 9:05 AM) - Breakfast observation revealed that R134 permitted staff to intermittently reposition the fork in the resident's hand, which promoted self feeding.</p> <p>2/3/19 (2:09 PM) - Nursing progress note documented "staff attempting to assist with meals but pushes staff away or curses at staff."</p> <p>2/3/19 (6:41 PM) - Nursing progress note included that "staff has been trying to assist with meals as he permits - often times he pushes the staff away."</p> <p>The approach to encourage self feeding by placing the utensil in the resident's hand instead of physically trying to feed the resident, was not included in the ADL (Activities of Daily Living) care plan.</p> <p>b. 11/26/16 - The care plan for psychotropic drugs (reviewed 1/31/19) related to receiving antipsychotic, antidepressant and antianxiety medication for treatment of dementia with behaviors.</p> <p>Physicians' orders for medications for anxiety included: - 7/25/17 to 3/27/18: Ativan (medication for anxiety) gel PRN. - 1/2/18 to 1/23/18: Klonopin (medication for panic attacks and anxiety) at bedtime.</p>	F 657		

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F 657	<p>Continued From page 19</p> <p>R134 had not received an antianxiety medication since 3/27/18. The care plan was not revised to reflect that R134 was no longer on antianxiety medications.</p> <p>c. 6/20/17 - A care plan for eating preference to eat meals on the couch or standing with tray table or tray in front of him related to being overwhelmed when sitting at a table. Goal was to not feel overwhelmed when eating meals. It was unclear how this would be measured. The one approach was to "allow the resident to eat meals sitting on the couch / standing at table with meal set up on tray table or tray in front of him."</p> <p>1/28/19 Lunch Observation - R134 was seated alone at a dining table, however an unidentified female resident was placed directly across from R134 at the same table. E25 (Activity Assistant) verbally cued the resident to eat. R134, in addition to drinking milk, only ate a few bites of chocolate cake and chicken parmesan at this meal.</p> <p>Meals when R134 sat without other residents at the dining table, had a fork intermittently placed in the resident's hand and ate 76 - 100% of his meal: 1/29/19 (breakfast); 1/31/19 (lunch); and 2/1/19 (breakfast).</p> <p>2/1/19 (3:40 PM) - An interview with E1 (NHA) revealed R134 had lived alone for years and does better when away from other residents, including not having a roommate.</p> <p>The approach to be seated alone, away from other residents, at a dining table was not included as an eating preference.</p>	F 657			

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F 657	Continued From page 20 Findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) during the exit conference beginning at 4:00 PM.	F 657			
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §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,	F 676		3/22/19	

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F 676	<p>Continued From page 21</p> <p>(ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview it was determined that the facility failed to provide the necessary services to maintain or improve ADLs in the area of eating and toileting for one (R134) out of five sampled residents for ADL care. Findings include:</p> <p>Review of R134's clinical record revealed:</p> <p>Cross Refer F657, Examples a and c.</p> <p>a. Eating</p> <p>9/1/16 - The care plan for ADLs (revised 1/10/19) included the approach to set up trays for meals, assist with feeding if needed, and monitor to ensure adequate intake of food and fluids.</p> <p>Random meal observations: 1/28/19 (lunch) - E25 (Activity Assistant) verbally encouraged R134 to eat, then walked away. An unidentified female resident sat across from R134 and attempted to verbally cue R134 to eat. R134 only ate a few bites of chocolate cake and chicken parmesan entree at this meal.</p> <p>1/29/19 (breakfast) - R134 sat alone at the table and began picking up eggs with fingers. At 8:43 AM, E25 (Activity Assistant) spoke with resident briefly before leaving the table. R134 returned to eating with fingers until E17 (RN, Staff Developer) physically cued the resident to use the fork at 8:47 AM by placing the fork in the resident's hand. R134 continued to eat almost all of the meal using the utensil.</p> <p>1/31/19 (breakfast) - After being served the meal</p>	F 676	<p>A.) 1.) The Center cannot retroactively change the observations made on R134 regarding eating and toileting on 1/28, 1/29, and 1/31 of 2019. 2.) Once informed of the observations, the center educated all staff on the unit regarding R134's preferences and his needs as it relates to maintaining and improving ADL's in the area of eating and toileting; and care plans were updated accordingly.</p> <p>B.) 1.) All residents have the potential to be affected. 2.) A whole house audit of resident's eating and toileting care plans will be conducted; the plans will be adjusted to maintain the highest possible level of function with toileting and eating.</p> <p>C.) 1.) RCA determined that care plans were not personalized for the purpose of potentially maintaining and improving in a manner that electronic C.N.A. assignments did not contain the personalization needed. 2.) MDS care plan check list, used by IDT prior to care plan meeting, will contain a review for the maintaining and improvement of ADLs' upon admission, quarterly, and significant change MDS's. 3.) Staff Developer and / or designee will create an education on ADL Care plans that maintains and improved ADL functions for residents. 4.) Additionally, staff will be educated about the need to follow the care plan.</p>		

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F 676	<p>Continued From page 22</p> <p>at 8:20 AM, R134 drank the cup of milk then sat and looked around the room. The resident, who was alone at the table, made no attempt to eat any food from the plate and received no physical cueing by placing the fork in the resident's hand.</p> <p>1/31/19 (lunch) - R134 was seated alone at a dining table and was served lunch at 12:12 PM with the fork stuck upright into the entree. After drinking the cup of milk, the resident sat looking around the room. At 12:20 PM, the resident attempted to stab the roll with the fork, then put down the fork. R134 repeatedly picked up the empty glass, looked in it and put it back on the table. E26 (Activity Assistant) refilled the milk which the resident immediately drank. E26 placed the fork in R134's hand at 12:25 PM then the resident started to eat the meal. E26 stayed with the resident for cueing and R134 ate over 90% of the entree along with a third cup of milk.</p> <p>1/31/19 (12:45 PM) - An interview with E16 (CNA) revealed that residents who eat in the dining room were independent eaters. After describing the aforementioned observations, E16 stated s/he did not realize R134 needed more help with eating and would check on the resident after feeding assigned residents who were dependent on staff.</p> <p>2/1/19 (10:14 AM) - During an interview with E27 (NP) it was revealed that R134 had advanced dementia and a decline in function would be expected over time.</p> <p>2/1/19 (3:40 PM) - During an interview, E1 (NHA) explained that R134 had lived alone for years and does better when by him/her self, away from other residents.</p>	F 676	D.) 1.) DON and designees will monitor ADL care plan changes for consistency with maintaining and improving ADL functioning of ADL's and compliance of staff following the plan. Monitoring will consist of five (5) care plans a week after audit. 2.) Audits will be reviewed in monthly QA until 100% compliance is achieved for three (3) consecutive months.		

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F 676	Continued From page 23 b. Toileting / Incontinence Care 6/17/15 - The care plan for incontinence (reviewed 1/31/19) included approaches to check and change as appropriate, skin checks every 2 hours and report any signs of skin breakdown. 12/31/18 - A Nursing Progress note documented that R134 was no longer on toileting program. 1/8/19 - The quarterly MDS Assessment documented that R134 was always incontinent of bowel and bladder. 1/29/19 - Observed resident being taken to the activity area in the common area around 9:10 AM immediately after breakfast for sensory activity. At 11:35 AM the resident was placed at a dining table for lunch without being taken to the bathroom for changing. 1/31/19 - Observation of breakfast being served at 8:20 AM and R134 being taken to the activity area at 9:12 AM. E14 (Activity Aide) engaged R134 with pictures and at 10:07 AM positioned the resident to observe the music and movement activity. At 11:30 AM resident was placed at a dining table in the independent dining room for lunch without being taken to the bathroom for changing. Findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) during the exit conference beginning at 4:00 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	F 688		3/22/19	

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F 688	<p>Continued From page 24</p> <p>range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and</p> <p>§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.</p> <p>§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:</p> <p>Based on record review, observation and interview it was determined that the facility failed to implement palm protectors as ordered for one (R35) out of two residents sampled for positioning / mobility. Findings include:</p> <p>Review of R35's clinical record revealed:</p> <p>12/10/15 - A care plan problem for actual contractures included palm protectors to both hands as ordered (6/8/18).</p> <p>6/5/18 - Physicians' orders included bilateral (both sides) palm protectors as tolerated four hours on and one hour off.</p> <p>8/16/18 and 11/9/18 - The quarterly MDS assessments recorded no splint/brace and no ROM (Range of Motion) for at least 15 minutes per day.</p> <p>Observations with no palm protectors in place and palms bent downward toward the forearm: 1/31/18: 8:10 AM, 11:00 AM, and 1:14 PM.</p>	F 688	<p>A.) R35's palm protector is now in the electronic medication administration record. 2.) RCA determined that splint device schedule was not scheduled in Medication Administration Record.</p> <p>B.)1.) Any resident with a splint device with similar schedule could be affected. 2.) Center will conduct a whole house audit on all devices and schedules. All devices will be re-screened by therapy for use and determination and confirmation of schedule use to care plan.</p> <p>C.)1.) All splint like devices will be captured on the Medication Administration Record instead of nursing aide flow sheet. 2.) Therapy Splint Order form will now contain verification check-off that splint and schedule has been entered into MAR. 3.) Staff Developer and / or designee will create an in-service on the new documentation change for clinical and therapy staff; and added to new hire</p>		

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F 688	Continued From page 25 2/1/18: 8:15 AM and 2:30 PM. Review of eTAR (electronic treatment administration record) and CNA documentation found no entry for the use of the palm protectors. 2/1/19 (2:20 PM) - An interview with E16 (CNA) determined that R34 did not use any type of splint / brace. 2/1/19 (2:28 PM) - During an interview with E28 (CNA) who cared for resident all day, when asked if resident had any type of splint or palm protector to wear on wrists, E28 responded, "No." 2/1/19 (2:35 PM) - An interview with E19 (Rehabilitation Director) verified in the computer there was nothing about the discontinuation of the palm protectors. 2/4/19 - Review of contracture measurements showed no decline in wrists. 2/4/19 (8:40 AM) - An interview with E3 (ADON) confirmed that order for the palm protectors was not entered correctly by therapy so the information to use the palm protectors never appeared for staff to know to use them. These findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) during the exit conference beginning at 4:00 PM.	F 688	orientation. D.) 1.) DON and / or designees will monitor all new splint device and splint-like device care plans for accuracy and correct placement on electronic medication administration record (EMAR). All clinical staff will conduct random audits that placement matches the electronic medication record (EMAR). Audit will be done on five (5) devices, new and / or old, weekly. 2.) Audits will be reviewed in monthly QA until 100% compliance is achieved for three (3) consecutive months.		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and	F 689		3/22/19	

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F 689	<p>Continued From page 26</p> <p>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, observation, interview and review of other facility documentation it was determined that the facility failed to provide adequate supervision to prevent falls for one (R134) out of eight sampled residents for accidents. Findings include:</p> <p>Cross Refer F637 and F676. Review of R134's clinical record revealed:</p> <p>2/10/16 - A care plan for impaired mobility (revised 1/10/19) included that R134 was independent for ambulation, bed mobility and transfer. Approaches included: call light in reach; personal items in reach; well lit environment free of clutter; non-slip footwear; reinforce need to call for assistance; hipsters and low bed.</p> <p>Physician notes described reduction of antipsychotic medication with hopes of R134 having less stiffness and improved mobility: 7/6/18; 8/14/18; and 9/19/18.</p> <p>10/3/18 - 10/22/18 - Physical Therapy (PT) documentation showed R134 received PT services to reduce the risk for falls. When discharged from PT, R134 needed supervised transfers, stand by assist for walking with occasional verbal cues. Ambulation at 175 feet.</p> <p>11/22/18 - Physician orders documented that antipsychotic medication returned to prior dose of 0.5 mg in the morning and 1 mg in the evening.</p>	F 689	<p>A.) The center conducted a Root Cause Analysis (RCA) regarding R134's falls. R134's care plan has been revised to reflect to encourage the participation in supervision interventions during the time spans identified in Root Cause Analysis.</p> <p>B.) 1.) Residents with similar patterns of falls may be at risk. 2.) Residents with similar fall patterns will be reviewed for root cause analysis. Interventions and care plans will be updated accordingly.</p> <p>C.) 1.) Staff developer will teach all licensed staff on how to participate and collect data for a RCA. The RCA process will be used to identify specific time spans and interventions to provide increased supervision interventions. 2.) The care plan and point of care will be updated accordingly with these interventions.</p> <p>D.) 1.) DON and / or designee will audit all RCA's to monitor that additional supervision has been identified and included in the fall care plan. 2.) Audits will be reviewed in monthly QA until 100% compliance is achieved for three (3) consecutive months.</p>		

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F 689	<p>Continued From page 27</p> <p>Review of Fall Event documentation (computerized form) and facility investigation documents revealed R134 was wearing hipsters and non-skid socks for the following falls:</p> <p>Fall 1 11/26/18 (3:50 PM) - Resident had a "witnessed fall 11/26/18 in common area with no noted injuries and did not hit head." R134 "attempted to sit in a chair in the common area and fell to the floor." Resident is "independent with transfers and ambulation." E3 (ADON) documented the investigation recommendation for PT screen. 12/3/18: PT evaluation revealed resident with "poor safety awareness without significant functional change." R134 was "able to transfer on different chairs in unit, assist provided by staff as needed. Resident needed redirection to sit and rest as fatigue was not recognized."</p> <p>Fall 2 12/12/18 (10:40 PM) - "Resident constantly walking in the common area, stumbled down into the floor . . . was witnessed but could not get the resident in time to prevent him to land on the floor on his buttock towards more on the R (right) side area of the body... R forehead with quarter size" abrasion. Neurological assessment normal. E3's (ADON) investigation recommended a PT screen. 12/14/18: Interdisciplinary review note documented R134 "has increased need for assistance with bed mobility and eating for this review". . . the increased assistance "appears cognitive in nature and not resident's ability to physically perform task. Resident with advanced dementia. . ."</p> <p>Fall 3 12/18/18 (8:40 PM) - R134 "found in another residents room sitting on floor next to bed" . . .</p>	F 689			

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F 689	<p>Continued From page 28</p> <p>"Small abrasion noted to mid upper back." E2's (DON) investigation had no new recommendations.</p> <p>1/10/19 - A nursing progress note included "at times require 1-2 staff to transfer or ambulate."</p> <p>Fall 4 1/11/19 (6:29 PM) - "Resident was ambulating in common room. He tried to get in between two chairs and bumped one of the chairs, lost his balance and slid to the floor onto his bottom. Witnessed by CNA. No injury." E3's (ADON) investigation recommended PT screen.</p> <p>Fall 5 1/12/19 (3:23 PM) - "Resident was standing next to a table in activities becoming intrusive with others seated at the table." R134 "started to back up from table and became tangled in others w/c" (wheelchairs). "Lost balance and was helped down to floor in sitting position, no injury noted." E3's (ADON) investigation recommended PT screen.</p> <p>- 1/15/19: Psychotropic Reduction Meeting documented a reduction in Trazodone (antidepressant used for sleeplessness) due to recent falls.</p> <p>- 1/16/19: PT evaluation revealed resident with "poor safety awareness while attempting to ambulate between wheelchairs and chairs on the unit in the common area. Skilled services not required at this time."</p> <p>Fall 6 1/25/19 (1:45 PM) - Heard "sound in the common area" and R134 was found "sitting on floor with back against the couch." Resident "had been sitting on the couch, got up and tried to sit down and missed the couch."</p> <p>- 1/29/19: Psychiatric NP note described</p>	F 689			

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F 689	<p>Continued From page 29</p> <p>increased pacing and sleeplessness with the reduction of Trazodone with a fall on 1/25/19. Dose reduction failed.</p> <p>1/31/19 Random observation found:</p> <ul style="list-style-type: none"> - 9:08 AM: R134 attempted to stand and slide between the wheelchair and the dining table but could not get out. No staff saw or approached the resident to redirect. - 10:12 AM: resident attempted to stand while watching other residents during music and movement activity, but unable to stand even though there was no table in front of the resident. - 10:17 AM: E14 (Activity Director) attempted to assist R134 to stand and walk, but the resident was unable to do so. - The resident stood up at least 29 times during breakfast, activities and lunch. <p>1/31/19 (12:45 PM) - E16 (CNA) stated during an interview that after lunch R134 sits in the common area in a lounge chair.</p> <p>1/31/19 (4:07 PM) - A RNAC progress note included "Increased frequency of needing assistance with ADLs. Increased assistance appears cognitive in nature, and not resident's ability to physically perform task."</p> <p>Fall 7 Nursing progress notes review revealed:</p> <ul style="list-style-type: none"> - 2/2/19 (3:00 PM) - "CNA saw resident laying on right side in common area. Assessed by nurses . . . Noticed resident had a laceration by the right eyebrow region." Area cleansed and steri-strips applied. - 2/3/19 (7:21 AM) - "Wound appears reopened. Resident notes to be manipulating strips and hand noted to area." Area cleaned and new steri-strips applied. 	F 689			

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F 689	Continued From page 30 - 2/3/19 (2:09 PM and 6:41 PM) - R134 moved from sitting to standing position frequently. 2/4/19 (8:00 AM) - Observed resident transferred from chair scale to lounge chair with extensive assistance by two staff while R134 wore a soft helmet. 2/4/19 (8:05 AM) - An interview with E29 (night time LPN) revealed that R134 had been pacing, sitting up in bed for a long time. The LPN added that with the Trazodone, R134 will sleep from around 11:00 PM to around 7:00 AM. 2/4/19 (8:35 AM) - An interview with E3 (ADON) to determine what was done to prevent the resident from falling now that the last two PT evaluations offered no additional information. E3 stated "Not sure what else we can do," since the resident "had always gotten up." Therapy said it was "safety awareness and now that he is weaker, we can't put him on a 1 to 1, but keep an eye on him." . . the staff person on patrol was addressing "a different resident at the time of this last fall." The facility failed to adequately supervise R134 in the common area to prevent six falls in the common area and one in another resident's room. Findings were reviewed with E1 (NHA), E2 (DON), and E3 (ADON) during the exit conference on 2/4/19 beginning at 4:00 PM.	F 689			
F 732 SS=E	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily	F 732		3/22/19	

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OMB NO. 0938-0391

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F 732	Continued From page 31 basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility failed to post required nurse staffing information on a daily basis. Findings include:	F 732	A.)Once informed, the center immediately posted staffing. B.)All residents have the potential to be effected.		

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F 732	Continued From page 32 1/28/19 (7:30 AM) - Observation of nurse staffing information posted in the front lobby that was dated 1/25/19. 1/28/19 (2:34 PM) - An interview with E36 (Business Office) revealed E36 usually received the forms for the weekend but did not get them this past Friday. The facility did not post the nurse staffing information over the weekend. Findings were reviewed with E1 (NHA), E2 (DON), and E3 (ADON) during the exit conference on 2/4/19 beginning at 4:00 PM.	F 732	C.) 1.) Three (3) sign holders will be used to display a rolling three days of staffing, when needed, so as to avoid having to pull next day from behind. 2.) Copies of weekend staffing will be left in manager on duty book, prior to weekend. 3.) Inspection of staffing signs will be added to manager on duty checklist. 4.) Staff Developer and / or designee will develop in-service for all the administrative staff. D.) 1.) NHA and / or designee will audit sign postings daily. 2.) Audits will be reviewed in monthly QA until 100% compliance is achieved for three (3) consecutive 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 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	F 812		3/22/19	

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F 812	<p>Continued From page 33</p> <p>by: Based on observation and interview it was determined that the facility failed to store food in a safe and sanitary manner in the main kitchen and one (Lewes unit) out of three nursing units. Findings include:</p> <p>1. Main kitchen initial tour conducted 1/28/19 between 7:52 AM - 8:21 AM revealed:</p> <p>1. Walk-in refrigerator</p> <p>a. Unlabeled open food items</p> <ul style="list-style-type: none"> - 3 different lunch meats, milk, shredded cheese, uncovered defrosting tray of pasta entree, and dirty floor. - 1/2 gallon carton of Almond Breeze. - Gallon jug of whole milk. - Large bag of shredded mozzarella. - Large pieces of lunchmeat (2 ham and 1 turkey). - Oatmeal-appearing food product in a small stainless serving tray, covered with clear wrap. <p>b. Uncovered food</p> <ul style="list-style-type: none"> - Large tray of defrosting pasta entree with tomato sauce on the bottom shelf ...the foil had blown (from the internal air) off the one side exposing the food. - Large bag of celery stalks. <p>c. Dirt and paper on the floor beneath shelving.</p> <p>2. Dry storage</p> <ul style="list-style-type: none"> - Large unlabeled open bag of pasta noodles - Dirt, light color gritty substance, paper, plastic utensils on the floor beneath the shelving. - Personal belongings hanging on the shelving units (coat, sweater, rain poncho). <p>1/28/19 (8:15 AM) - An interview with E30</p>	F 812	<p>A.) Upon discovery: all items noted the Walk-In were labeled, dated and covered; walk-In floor areas were cleaned; item noted in the dry storage room was labeled and dated; dry storage room floor area was cleaned of and all personal items were removed. Nourishment refrigerator identified has the correct temperature log format.</p> <p>B.) All residents have the potential to be affected.</p> <p>C.) 1.) RCA determined that checklist form did not: breakout covering, dating, and labeling as individual check-offs, verify that personal items were located in storeroom, or that individual freezer floors were checked for cleanliness. 2.) The Dining Services opening and closing check list will be updated to include checking for cleanliness of walk-in floors and dry storage room (including absence of personal items). The check list will be revised to separate: covering, labeling, and dating of food. Current checklist only has one check off box to include "All food covered, labeled, and dated". Additionally, the Food Service Director and / or designee will educate all dietary staff on the revised checklist and add education to orientation. 3.) Temperature logs will be color coded to distinguish between the medication and nourishment refrigerator; Staff Educator/designee will educate staff on the color coded forms.</p> <p>D.) 1.) The Food Service Director will do</p>		

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F 812	<p>Continued From page 34</p> <p>(Kitchen Aide) who said that opened items in the refrigerator were to be dated with the date of opening and confirmed the unlabeled items in the refrigerator.</p> <p>1/28/19 (8:20 AM) - An interview with E31 (Kitchen Manager) to review the undated items and dirty flooring in the refrigerator and dry storage areas. E31 stated she was off the weekend and was not around.</p> <p>3. Nourishment refrigerator on Lewes Unit: 1/29/19 (9:15 AM) - Refrigerator temperature reading currently 40 degrees. Temperature log on the front of the refrigerator was labeled "Medication Refrigerator Temperature" log with range of 36-46 degrees. However the refrigerator contains pudding, juices, boxes of pre-thickened liquid and cold food storage temperature should not be above 41 degrees for food safety . The January, 2019 log revealed the following temperatures over 41 degrees: - January 3, 13, and 16: 42 degrees. - January 18: 44 degrees.</p> <p>1/31/19 (around 2:35 PM) - An interview with E21 (LPN) to inform of the temperature log on the nourishment refrigerator from January, 2019 was one for a medication refrigerator. The LPN confirmed 5 refrigerator temperatures over 41 degrees, including today (1/31/19) which was 43. After discussion about the maximum temperature for food is 41 degrees, E21 said she would talk with E31 (Kitchen Manager) to see about getting the right temperature log. Surveyor showed E21 a blank temperature log dated 2016 found on top of the refrigerator which contained the correct temperatures for a nourishment refrigerator.</p> <p>1/31/19 (around 2:50 PM) - Observed E21 place</p>	F 812	<p>daily audits to monitor that food items are labeled, dated covered, walk in floors are clean, dry storage room is clean without personal items hanging, and use of proper temperature logs. 2.) Audits will be reviewed in monthly QA until 100% compliance is achieved for three (3) consecutive months.</p>		

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F 812	Continued From page 35 one of the 2016 temperature logs on the front of the nourishment refrigerator and dated it for February, 2019.	F 812			
F 842 SS=D	Findings were reviewed with E1 (NHA), E2 (DON), and E3 (ADON) during the exit conference on 2/4/19 beginning at 4:00 PM. Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;	F 842		3/22/19	

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F 842	<p>Continued From page 36</p> <p>(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.</p> <p>§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.</p> <p>§483.70(i)(4) Medical records must be retained for-</p> <p>(i) The period of time required by State law; or</p> <p>(ii) Five years from the date of discharge when there is no requirement in State law; or</p> <p>(iii) For a minor, 3 years after a resident reaches legal age under State law.</p> <p>§483.70(i)(5) The medical record must contain-</p> <p>(i) Sufficient information to identify the resident;</p> <p>(ii) A record of the resident's assessments;</p> <p>(iii) The comprehensive plan of care and services provided;</p> <p>(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;</p> <p>(v) Physician's, nurse's, and other licensed professional's progress notes; and</p> <p>(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, it was determined that the facility failed to ensure that medical records were complete and accurately documented for two (R110 and R134) out of 30 sampled residents for investigations. Findings</p>	F 842	<p>A.) Center cannot retroactively correct typographical error by providers in medical record for Resident R110 and R134 on the dates noted. Once notified of the error the center educated the</p>		

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F 842	Continued From page 37 include: 1. Review of R110's clinical record revealed: 12/23/18 - New physician's order: Code Status: Do Not Resuscitate (DNR). 12/24/18 - CPR/DNR Documentation Form: E33 (Medical Doctor), R110 and E34 (LPN) signed that R110 was now a DNR. 1/9/19 and 1/24/19 - Progress Note: E35 (NP) documented that R110's code status was "full scope of treatment". 2/1/19 11:00 AM - An interview with E35 (NP) confirmed she incorrectly documented R110's code status as "full scope of treatment" when he was a DNR and that she would have these progress notes corrected. 2/1/19 1:00 PM - An interview with E9 (RN, UM) confirmed the above error in documentation. 2. Review of R134's clinical record revealed: Physicians' orders for psychotropic medications: - 3/14/18 - 1/15/19: Trazodone 150 mg (antidepressant used for sleeplessness) - 1/23/18 - 11/7/18: Haldol 1 mg at bedtime (antipsychotic) a. 11/6/18 - E32 (Psychiatric NP) note listed in Psychotropic Medication section that R134 received Haldol 150 mg at bedtime (should be Trazodone). b. 1/15/19 - E32 (Psychiatric NP) note listed in Assessment/Plan section: Tramadol (should be Trazodone). [Tramadol is an opioid pain	F 842	practitioner of accurate domination. B.) All residents seen by these specific providers could be affected. C.) Medical Director and DON and/or Designee will draft a written awareness and education related to accurate documentation All current providers will receive the education. D.) 1.) DON and / or clinical designees will audit five (5) Provider notes weekly for accuracy. Twenty (20) percent of the notes will be from the providers mentioned in the violation. 2.) Audits will be reviewed in monthly QA until 100% compliance is achieved for three (3) consecutive months.		

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F 842	Continued From page 38 medication] 2/04/19 (11:43 AM) - An interview with E32 (NP) to discuss R134 and review the documentation errors revealed that E32 planned on being in the facility later today and would look at, and correct, the computerized documents by adding an addendum. 2/4/19 (around 1:40 PM) -A follow-up interview with E32 (NP) confirmed s/he corrected the errors. Findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) during the exit conference beginning at 4:00 PM.	F 842			
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization ; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period ; (iii) The resident or the resident's representative has the opportunity to refuse immunization ; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza	F 883		3/22/19	

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F 883	<p>Continued From page 39</p> <p>immunization; and</p> <p>(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.</p> <p>§483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-</p> <p>(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;</p> <p>(iii) The resident or the resident's representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:</p> <p>(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and</p> <p>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, interview and review of other facility documentation it was determined that the facility failed to administer a pneumococcal vaccination for one (R13) out of six residents sampled for pneumonia vaccination review. Findings include:</p>	F 883	<p>A.) R13 has been given the immunization. A RCA was conducted Root Cause Analysis indicating that the immunization was missed during conversion from short term care to home admission turning into a long term care stay.</p>		

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F 883	<p>Continued From page 40</p> <p>2001 - Facility policy entitled Pneumococcal Vaccine (revised October, 2014) included:</p> <ul style="list-style-type: none"> - Assessments of pneumococcal vaccination status will be conducted within five (5) working days of the resident's admission if not conducted prior to admission. - Pneumococcal vaccines will be administered to residents (unless medically contraindicated, already given or refused) per our facility's physician-approved Pneumococcal vaccination protocol. - Administration of the pneumococcal vaccines or revaccinations will be made in accordance with current Centers for Disease Control and Prevention (CDC) recommendations at the time of the vaccination. <p>Review of R13's clinical record revealed:</p> <p>10/25/18 - Admission to facility.</p> <p>10/25/18 (6:10 PM) - Nursing progress note included that the resident expressed the desire for a pneumonia vaccination.</p> <p>October, 2018 - January 2019 - Review of immunization information, physicians' orders and eMAR found no evidence the resident received a pneumonia vaccination while in the facility.</p> <p>1/31/19 (3:25 PM) - During an interview with E8 (RN, UM) to review the process for administration of pneumonia vaccine when resident expresses desire on admission, E8 stated that the resident's vaccination status is checked on the State's vaccination software (DelVax) and is written on the immunization consent form. E8 reviewed R13's immunization paper and found no notation on it that the DelVax was checked to see the resident had been vaccinated.</p>	F 883	<p>B.) 1.) All Residents who arrive to center with initial plans for short term services and then remain for long term services could be affected. 2.) A review of all Residents that converted from short term to long term care, since January 1, 2019, will be completed. Immunizations will be offered accordingly.</p> <p>C.) 1.) DON and / or designee will create a Immunization audit tool to track when residents convert from short term to long terms and compliance to immunization to schedule. 2.) Staff Developer and/or designee will educate license staff on the new process.</p> <p>D.) 1.) DON and / or clinical designees will audit immunization schedules for two consecutive quarterly care plans for Residents. 2.) Audits will be reviewed in monthly QA until 100% compliance is achieved for three (3) consecutive months.</p>		

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

PRINTED: 03/01/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/04/2019
NAME OF PROVIDER OR SUPPLIER HARBOR HEALTHCARE & REHAB CTR			STREET ADDRESS, CITY, STATE, ZIP CODE 301 OCEAN VIEW BLVD LEWES, DE 19958		
(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 883	Continued From page 41 1/31/19 (around 3:40 PM) - E21 (LPN) provided the surveyor a printout from DelVax that showed R13 had received two 13-valent pneumococcal conjugate vaccines in the past with the latest administration on 12/27/17. After one year from the administration date R13 would be eligible the for the 23-valent pneumococcal polysaccharide vaccine. R13 was eligible for the 23-valent pneumococcal vaccination after 12/27/18. E21 added that s/he would check with the family to see if the vaccine was still desired and get the order. Findings were reviewed with E1 (NHA), E2 (DON), and E3 (ADON) during the exit conference on 2/4/19 beginning at 4:00 PM.	F 883			



DELAWARE HEALTH AND SOCIAL SERVICES

Division of Health Care Quality

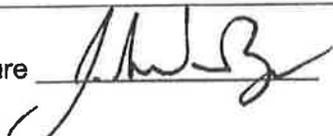
Office of Long Term Care Residents Protection

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

STATE SURVEY REPORT

NAME OF FACILITY: Harbor Healthcare & Rehabilitation Center **DATE SURVEY COMPLETED:** February 4, 2019

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
<p>3201</p> <p>3201.1.0</p> <p>3201.2.0</p>	<p>The State Report incorporates by reference and also cites the findings specified in the Federal Report.</p> <p>An unannounced annual and complaint visit survey was conducted at this facility from January 28, 2019 through February 4, 2019. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census the first day of the survey was 155. The investigated sample size was 79.</p> <p>An emergency preparedness survey was also conducted during the same time period. There were no emergency preparedness deficiencies identified based on observation and interviews.</p> <p>Regulations for Skilled and Intermediate Care Facilities</p> <p>Scope</p> <p>Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.</p> <p>This requirement is not met as evidenced by: Cross Refer to the CMS 2567-L survey completed February 4, 2019: F550, F558, F622, F623, F625, F657, F676, F688, F689, F732, F812, F842, and F883.</p>	<p>This plan of correction received on February 11, 2019, constitutes my written allegation of compliance for the alleged deficiencies cited; Cross Refer to CMS 2567-L, survey completed February 4, 2019: F550, F558, F622, F623, F625, F657, F676, F688, F689, F732, F812, F842, and F883. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This plan is submitted to meet requirements established by State and Federal law.</p>	<p>March 22, 2019</p>

Provider's Signature  Title Administrator Date 2-19-2019



DELAWARE HEALTH AND SOCIAL SERVICES

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STATE SURVEY REPORT

NAME OF FACILITY: Harbor Healthcare & Rehabilitation Center **DATE SURVEY COMPLETED:** February 4, 2019

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
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§ 1144	<p>Security Act.</p> <p>Influenza Immunizations</p> <p>(a) Nursing and assisted living facilities shall annually offer, beginning no later than October 1st through March 1st of the following year, onsite vaccinations for influenza vaccine to all employees with direct contact with patients at no cost and contingent upon availability of the vaccine.</p> <p>(b) The facility shall keep on record a signed statement from each employee stating that the employee has been offered vaccination against influenza and has either accepted or declines such vaccination.</p> <p>(c) Employment will not be contingent on influenza vaccination.</p> <p>Based on review of other facility documentation and interview it was determined that the facility failed to keep a signed statement from each employee accepting or declining the influenza vaccination. Findings include:</p> <p>9/10/18 - Facility policy entitled Influenza Vaccination for Employees included:</p> <p>1. Employees shall be provided the influenza vaccine during the annual influenza vaccination campaign. Employees will be encouraged to obtain vaccination by November 1st of each calendar year.</p> <p>2. That all personnel will be provided with education that includes: flu vaccination; non-vaccine control measures; and the diagnosis, transmission, and potential impact of influenza. All employees will be asked to obtain vaccine or sign declaration on the influenza vaccination employee statement each year (A medical declaration must be signed by the employee's primary care physician and provided to the facility). . . by a practitioner licensed to practice in state which facility resides. . .</p>	<p>A.) Center is in the process of obtaining written declinations.</p> <p>B.) All Residents have the possibility of being affected.</p> <p>C.) DON will educate Staff Educator on the need to obtain a signed flu declination form when appropriate.</p> <p>D.) 1.) DON designee will monitor all new hires for remainder of Influenza season for declinations with form and education. 2.) Audits will be reviewed in monthly QA until 100% compliance is achieved for three (3) consecutive months.</p>	March 22, 2019
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Provider's Signature _____ Title _____ Date _____



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STATE SURVEY REPORT

NAME OF FACILITY: Harbor Healthcare & Rehabilitation Center **DATE SURVEY COMPLETED:** February 4, 2019

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	<p>3. If hired after November 1, vaccine will be administered within 1 week of employment (until April 1 of calendar year, or as deemed by CDC recommendations.)</p> <p>4. Employees who are vaccinated by their private physician or other provider must submit written verification from their provider that they have received the vaccine.</p> <p>2/1/18 (11:50 AM) – Interview with E17 (Infection Control Practitioner) who provided an influenza binder that contained the information provided to employees, the form to accept or decline the vaccination as well as the facility policy. E17 stated it had been hard to get the declinations returned but did keep track of which employees who did and did not get the vaccine offered at the facility. Review of the binder containing the returned forms and the list of active employees revealed out of the 225 employees, at least 193 with direct resident contact, discovered:</p> <ul style="list-style-type: none"> - 109 employee statements who received the influenza vaccination in the facility. - 12 employees provided documentation the vaccination was received outside the facility (e.g., another employer, pharmacy, physician office). - 1 employee with a note from the private physician. - No employees who declined the vaccination had a signed statement. <p>Findings were reviewed with E1 (NHA), E2 (DON), and E3 (ADON) during the exit conference on 2/4/19 beginning at 4:00 PM.</p>		

Provider's Signature _____ Title _____ Date _____