

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

PRINTED: 09/25/2020
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 02/18/2020
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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 February 10, 2020 through February 18, 2020. The facility census the first day of the survey was 151. During this period an Emergency Preparedness Survey was also conducted by the State of Delaware's Division of Health Care Quality, Office of Long Term Care Residents Protection in accordance with 42 CFR 483.73.	E 000		
F 000	INITIAL COMMENTS An unannounced annual and complaint survey was conducted at this facility from February 10, 2020 through February 18, 2020. The facility census the first day of the survey was 151 (one hundred fifty-one). The sample size was 32 (thirty-two). Abbreviations and Definitions used in this report are as follows: 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; - Total Dependence - full staff performance every time activity performed; ADON - Assistant Director of Nursing; BIMS (Brief Interview for Mental Status) - test to measure thinking ability with score ranges from 0 to 15; 13-15: Cognitively intact; 8-12: Moderately impaired; 0-7: Severe impairment;	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 03/20/2020
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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	Continued From page 1 C-diff - bacterial infection that causes mild to life-threatening forms of diarrhea and inflammation; CCD - Continuity of Care Document in facility electronic medical record; CDC - The Centers for Disease Control and Prevention is the leading national public health institute of the United States; CNA - Certified Nurse's Aide; Cognition - mental processes or thinking; Cognitively Impaired - mental decline including losing the ability to remember, understand, talk or write; Delusion - false belief that is thought to be true; Dementia - brain disorder with memory loss, poor judgement, personality changes and disorientation; DON - Director of Nursing; etc. - further; Hallucinations - something that seems real but does not really exist (can be seen, heard or felt); i.e. - that is; Incontinence - loss of control of bladder and/or bowel function; LPN - Licensed Practical Nurse; Minimum Data Set (MDS) - standardized assessment forms used in nursing homes; NHA - Nursing Home Administrator; Occasionally Incontinent [urine] - less than 7 episodes of incontinence during the assessment week; Pain Scale - rating of pain severity on a 0 to 10 scale with 0 meaning no pain and 10 meaning the worst pain; PPE - Personal protective equipment is protective clothing, or other garments designed to protect the wearer's body from infection; PRN - as needed; Psychiatric - treatment of mental disorders;	F 000		

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F 000	Continued From page 2 Psychosis - loss of contact/touch with reality; Psychotropic (medication) - medication capable of affecting the mind, emotions and behavior; QAPI - Quality Assurance and Performance Improvement; RD - Registered Dietitian; RN - Registered Nurse; Severe Cognitive Impairment - unable to make own decisions; SW - Social Work / Social Worker; SWA - Social Work Assistant; UM - Unit Manager.	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 individuality. The facility must protect and promote the rights of the resident. §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.	F 550		4/17/20	

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F 550	<p>Continued From page 3</p> <p>§483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.</p> <p>§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.</p> <p>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record review and interview, it was determined that the facility failed to ensure care was provided in a way that promoted dignity during dining for one (R135) out of 25 residents sampled for investigations. Findings include: Cross refer F810. A review of R135's clinical record revealed: 10/4/18 - R135 was admitted to the facility. 1/17/2020 - A quarterly MDS documented that R135 needed one person supervision and assistance for eating. 2/10/2020 12:15 PM - R135 was observed reclining in bed with the head of the bed up approximately 70 degrees. The lunch tray was on the over the bed table straddling her lap. She was</p>	F 550	<p>1. R135 no longer resides in the facility.</p> <p>2. a. All residents that need extensive assistance with eating have the potential to be affected. b. All residents that trigger on the MDS for extensive assistance with feeding will have a therapy screen initiated by the MDS coordinator to monitor the appropriateness of the resident's adaptive equipment.</p> <p>3. a. The facility determined that the RCA was a lack of a system that initiated a therapy screen when a resident triggers for extensive assistance with feeding. Now when a resident triggers for extensive assistance for feeding on their MDS a therapy screen will be initiated by the MDS coordinator. b. The facility determined that the RCA was a lack of</p>	

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F 550	<p>Continued From page 4</p> <p>holding a bowl of soup in one hand. With the other hand R135 was dipping all her fingers in the soup bowl then licking them. There was spilled food staining her gown. When asked why she was not using the built-up utensils on her tray, R135 stated that she could not use them.</p> <p>2/12/2020 12:30 PM - R135 was observed reclining in bed with the head of the bed up. The lunch tray was on the over the bed table straddling her lap. There was food spilled on her gown. When asked how your lunch is, she replied, "Well I'm wearing it. I love soup, but it is too hard to eat it." Three unused utensils (spoon, fork and knife) with built up handles were on her tray.</p> <p>2/13/2020 12:40 PM - R135 was observed reclining in bed with the head of the bed up. The lunch tray was on the over the bed table straddling her lap. R135 was holding a bowl of soup to her lips with both hands trying to sip the soup, but it was spilling on her gown. When asked to try to use the built-up handled spoon on her tray, she was unable to grip it or pick it up off the tray. When the spoon was placed in R135's hand she was unable to turn it in a manner to allow her to eat the soup. There was a two-handed sippy cup containing juice that she was able to drink from, but not a cup for the soup. R135 stated that she would like staff to assist her in eating because she has become weaker and cannot pick up the spoon or fork herself.</p> <p>Findings were reviewed with E1 (NHA), E2 (DON), E27 (Regional VP), E17 (Medical Director) and E18 (Corporate Nurse) on February 18, 2020 during the exit conference beginning at approximately 1:15 PM.</p>	F 550	<p>system that prompted staff to initiate therapy screens when residents were not using their adaptive equipment or increase spillage. Staff Educator will educate the licensed nursing staff and the C.N.A.'s to initiate a therapy screen when a resident is not utilizing their adaptive equipment appropriately, or if the resident has increase of spillage on their clothing.</p> <p>4. a. Therapy/designee will do a weekly audits on 10 residents that have orders for adaptive equipment to monitor for the appropriateness use of their adaptive equipment. b. The results of these audits will be reported out in monthly QA and will continue until a 100% compliance is achieved for 3 months.</p>		

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F 656 SS=D	<p>Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)</p> <p>§483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -</p> <p>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and</p> <p>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).</p> <p>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.</p> <p>(iv) In consultation with the resident and the resident's representative(s)-</p> <p>(A) The resident's goals for admission and desired outcomes.</p> <p>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.</p> <p>(C) Discharge plans in the comprehensive care</p>	F 656		4/17/20

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F 656	<p>Continued From page 6</p> <p>plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview it was determined that for four (R43, R53, R58 and R91) out of 25 sampled residents the facility failed to ensure the comprehensive care plan accurately reflected the resident's current needs and / or contained measurable goals. Findings include:</p> <p>1. Review of R43's clinical record revealed:</p> <p>a. 1/30/18 - A care plan for the potential for impaired mobility included the goal that R43 would "maintain the highest level of functional mobility / transfer status." This goal was not measurable.</p> <p>b. 2/11/2020 - A care plan for diarrhea related to the resident has frequent diarrhea included the goal to "minimize episodes of diarrhea." This goal is not measurable.</p> <p>2/14/2020 (11:09 AM) - During an interview to review the care plan goals, E5 (RN, UM) explained that R43's diarrhea "will happen at times, then not again for a while."</p> <p>2/17/2020 (9:28 AM) - During an interview , E7 (RN) confirmed the goals were not measurable and would discuss with E5 (RN, UM). During a follow-up interview at 9:48 AM, E7 explained the goal for mobility was to keep R43 transferring and walking "at her current level" which was not included in the goal for either transfer or ambulation.</p>	F 656	<p>1. a. R43's care plan goals for mobility and the number of episodes of diarrhea are now measurable. b. R53's activities care plan has been updated to include "watching television" and includes the genre the resident enjoys. c. R58's care plan has been updated to include intervention for the use of the seat belt. d. R91's pain care planned was updated to include interventions for the use of a pain scale prior to and during treatments.</p> <p>2. a. All residents that have a diarrhea care plan have the potential to be affected. A whole house audit of residents that are care planned for diarrhea will be conducted by DON/designee . The care plans will be reviewed and monitored for a measurable goal and adjustments will be made accordingly. b. All residents that are care planned for watching television and/or movies have the potential to be affected. A whole house audit will be conducted by Director of Activity Director /designee on residents that are care planned for watching television and /or movies. Care plans will be reviewed and monitored for the inclusion of the resident's preferred genre and corrections will be made accordingly c. All residents that have a seatbelt have the potential be affected. A whole house audit will be conducted by DON/designee will be done on residents</p>		

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F 656	<p>Continued From page 7</p> <p>2. The following was reviewed in R53's clinical record:</p> <p>12/5/19 - An annual activity assessment documented that R53 "watches television in her room due to elevated anxiety (feeling worry, nervous or restless) in social settings. Watches the BET (Black Entertainment Television) channel."</p> <p>A care plan last reviewed 12/4/19 for activities included movies but did not include an intervention for watching television or indicate the preference to watch the BET channel.</p> <p>January 2020 - A monthly activity assessment documented that R53 watched television in her room.</p> <p>3. The following was reviewed in R58's the clinical record:</p> <p>3/29/19 - The annual MDS assessment documented that R58 was totally dependent for care and that a restraint (seat belt) was not used.</p> <p>The care plan last reviewed 12/18/19 did not contain any intervention for the use of a seat belt.</p> <p>2/12/2020 12:13 PM - R58 was observed in his wheelchair with a seat belt secured across the hips.</p> <p>2/17/2020 10:00 AM - During an interview E20 (CNA) revealed that "the seat belt is considered a restraint and that it may or may not be fastened."</p> <p>2/17/2020 around 10:20 AM - During an interview E7 (LPN) confirmed that she could not find any</p>	F 656	<p>that have seatbelts. Care plans will be reviewed and monitored that they include an intervention for the use of a seatbelts and corrections will be made accordingly.</p> <p>d. All residents that have an order for dressing changes have the potential be affected. The pain care plans for all residents that have a dressing changes will be audited by DON/designee monitored for interventions to assess for pain prior, during and after treatment. Corrections will be made accordingly.</p> <p>3. a. The facility determined that the RCA was lack of effectively communication from therapy to nursing regarding the order for the seatbelt so the care plan could be updated. Now in morning meeting the Rehab Director will discuss any new seatbelts orders with nursing so the care plan can be updated. b. The staff developer will review this new process with the Rehab Director and licensed nurses. c. The facility determined that the RCA was that a generic care plan template was used and the format lacked measurable goal. Now the facility is using a care plan template that has measurable goals for the diarrhea and the mobility. d. The facility determined that the RCA was that activities staff did not routinely include the resident's preferred genre when completing n activity assessment or when writing care plans. b. The staff educator will educate the activities staff to include preferred genre (Television and Movies) when conducting an activity assessment and writing care plans'. e. The facility</p>	

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F 656	<p>Continued From page 8 intervention in the care plan about the seat belt.</p> <p>2/17/2020 3:51 PM - During an interview E3 (ADON) stated that R58's care plan was updated to include the seat belt.</p> <p>4. Cross refer F697.</p> <p>The following was reviewed in R91's clinical record:</p> <p>8/13/19 - A physicians' order included to evaluate pain using a verbal pain rating ... pain scale level of 0 out of 10 twice a day.</p> <p>10/6/19 - A physician's order for a pain medication that could be administered every six hours if needed for pain.</p> <p>1/1/2020 - The care plan for the potential for pain documented a goal that pain would be controlled and acceptable to the resident. The care plan did not identify any approaches for pain control during dressing changes.</p> <p>2/14/2020 2:15 PM - During a dressing change/treatment observation when E13 (LPN) was removing the dressing adhered to R91's skin, R91 stated, "Don't do that it hurts." E13 did not stop the treatment process to assess R91's level of pain and/or offer pain medication.</p> <p>The care plan lacked interventions for the use of a pain scale, R91's acceptable pain level or medicating prior to, or during, treatments that may cause distress / pain.</p> <p>Findings were reviewed with E1 (NHA), E2 (DON), E27 (Regional VP), E17 (Medical</p>	F 656	<p>determined that the RCA was nursing did not systemically include interventions to assess the resident for pain prior, during and after treatments on pain care plans.</p> <p>d. Staff Educator will educate licensed nurses to include interventions to assess the resident for pain prior, during and after treatment on their pain care plans.</p> <p>4. a. The DON/designee will audit monthly all residents that are care planned for diarrhea and 10% of residents that are care planned for mobility for the inclusion of a measurable goal. b. The activities/designee will audit monthly all resident that are care planned to watch movies and/or television to monitor that the their preferred genre is included. c. The DON/designee will audit the care plans weekly of all residents that have seats belts to monitor that the care plan has an intervention for the use of the seatbelt. d. The DON/designee will audit weekly the pain care plans for all residents that have orders for a dressing change to monitor that they include interventions to assess for pain prior, during and after treatment. e. The results of these audits will be reported out in monthly QA and will continue until a 100% compliance is achieved for 3 months.</p>	

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F 656	Continued From page 9 Director) and E18 (Corporate Nurse) on February 18, 2020 during the exit conference beginning at approximately 1:15 PM.	F 656			
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (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. This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview, it was determined that for six (R5, R8, R22, R43, R59 and R122) out of 25 residents	F 657	1. a.R8's now has a documented care conference that includes participation and/or input of the IDT to include the	4/17/20	

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F 657	<p>Continued From page 10</p> <p>sampled for investigations, the facility failed to ensure that all required members of the Interdisciplinary Team ("IDT") participated in, or otherwise provided input, to the formation of comprehensive resident care plans. Findings include:</p> <p>The facility policy entitled "Comprehensive Care Plan" (last revised on January 13, 2018) included "The comprehensive care plan must be prepared with input from the IDT (includes but not limited to):</p> <ul style="list-style-type: none"> - attending physician; - a registered nurse with the responsibility for the patient, - a nurse aide with responsibility for the patient, - a member of food and nutrition services staff ... - other appropriate staff or professionals in disciplines as determined by the residents.... <p>1. The following was reviewed in R22's clinical record:</p> <p>6/5/19 - An Annual MDS assessment was prepared with an observation end date of 6/5/19.</p> <p>6/6/19 - A Care Conference Report note by E9 (SW Assistant) revealed that neither a doctor or his designee, a food/nutrition services staff nor a nurse aide participated in, or otherwise provided input, for R22's care plan meeting.</p> <p>2. The following was reviewed in R59's clinical record:</p> <p>9/16/19 - A Significant Change MDS assessment was prepared with an observation end date of 9/16/19.</p>	F 657	<p>attending physician, a registered nurse, a nurse aide and a member of the food and nutrition services. R8's care conference are correctly identified as annual vs. quarterly. b. R 22, R5, R59, R122 now have a documented care conferences that includes participation and/or input of the IDT to include the attending physician, a registered nurse, a nurse aide and a member of the food and nutrition services. b. R. 4 now has a documented care conferences that included participation and/or input of hospice and the IDT to include the attending physician, a registered nurse, a nurse aide and a member of the food and nutrition services.</p> <p>2. All residents that have a care conference has the potential to be affected.</p> <p>3. a. The facility determined that the RCA was a lack of a system to track the participation and input of the IDT for care conferences. The center has developed a system that will track the participation and or/input of the IDT to include the attending physician, a registered nurse, a nurse aide and a member of the food and nutrition services. SS will be responsible for maintaining the tracking tool. b. The Staff Educator will educate the IDT including SS on the new tool c. The Staff Educator will educate the IDT (SS, Nursing, C.N.A., attending physician, activities, food service) on the need to participate and/or provide input on all resident's care conference. c. The facility</p>		

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F 657	<p>Continued From page 11</p> <p>9/26/19 - A Care Conference Report note by E9 (SW Assistant) revealed that neither a doctor or his designee, a food/nutrition services staff nor a nurse aide participated in, or otherwise provided input, for R59's care plan meeting.</p> <p>2/14/2020 at 12:58 PM - An interview with E6 (UM) revealed that she typically participated at the care plan meeting on behalf of her nursing staff because she cannot have her nurses off the floor. Additionally, E6 stated that CNA's contribute verbally prior to the meeting, but did not attend the meetings because their presence was needed on the floor. Information is shared and then updates given to parties, as needed.</p> <p>3. Review of R8's clinical record revealed:</p> <p>4/29/19 - The quarterly MDS assessment was completed.</p> <p>5/2/19 - The care planning report included that the meeting would be rescheduled upon R8's return from the hospital.</p> <p>5/20/19 - A significant change MDS assessment was completed after R8's return from the hospital. There was no evidence that a care planning meeting was ever conducted to review R8's needs.</p> <p>4. Review R43's clinical record revealed:</p> <p>8/8/19 - An annual MDS assessment was completed.</p> <p>8/8/19 - The care conference report completed by E9 (SW Assistant) identified this annual care conference as a quarterly one in error. The only</p>	F 657	<p>determined that the RCA was the SW assistant was not trained on how to identify the different types of care conferences. The Staff Educator will educate the SW assistant on how to properly track and identify the type of care conference that is being held i.e. annual vs. quarterly care conferences.</p> <p>4. a. SS/designee will audit 100% of the care conference held for the month to monitor that there was participation and/ or input from the IDT team. b. SS/designee will audit 100% of the care conferences held for the month to monitor that the care conference that were held are identified properly i.e. annual vs. quarterly. c. The results of these audits will be reported out in monthly QA and will continue until a 100% compliance is achieved for 3 months.</p>		

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F 657	<p>Continued From page 12</p> <p>attende from the facility was E9 who spoke with R43's daughter by telephone. The report documented that R43 was currently ... "with palliative care. Nursing was unable to attend but reports resident is medically stable." Activities provided input regarding resident preference for self-directed activities. There was no evidence that the doctor or his designee, a food/nutrition services staff nor restorative nursing / CNA participated in, or otherwise provided input, for R43's care plan meeting.</p> <p>8/26/19 - R43 was admitted to hospice.</p> <p>9/5/19 - A significant change MDS was completed. There was no evidence on the care conference report that a care planning conference, including hospice input, was ever conducted.</p> <p>5. The following was reviewed in R5's clinical record:</p> <p>8/11/19 - An admission MDS assessment was prepared with an observation end date of 8/11/19.</p> <p>8/13/19 - A Care Conference Report note by E8 (SW) revealed that neither a food / nutrition services staff nor a nurse aide participated in, or otherwise provided input, for R5's care plan meeting.</p> <p>6. The following was reviewed in R122's clinical record:</p> <p>6/5/19 - A significant change MDS assessment was prepared.</p> <p>6/6/19 - A Care Conference Report note by E9</p>	F 657		

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F 657	Continued From page 13 (SW Assistant) revealed that neither a doctor or his designee, a food/nutrition services staff nor a nurse aide participated in, or otherwise provided input, for R22's care plan meeting. Findings were reviewed with E1 (NHA), E2 (DON), E27 (Regional VP), E17 (Medical Director) and E18 (Corporate Nurse) on February 18, 2020 during the exit conference beginning at approximately 1:15 PM.	F 657			
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for two (R53 and R100) out of five sampled residents reviewed for activities, the facility failed to provide activities of choice based on the activity assessment outlining resident preference. Findings include: 1. The following was reviewed in R53's the clinical record: 12/5/19 - An annual activity assessment documented that R53 "watches television in her	F 679	F 679 1. a. The licensed nurses, C.N.A.'s and the activity staff involved in R53's care have been educated on the residents choice of activities including the resident's preference to watch television in her room. b. The licensed nurses ,C.N.A.'s and activity staff involved in R100's care have been educated on the residents' choice of activities that includes listening to music.	4/17/20	

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F 679	<p>Continued From page 14</p> <p>room due to elevated anxiety in social settings. Watches the BET (Black Entertainment Television) channel".</p> <p>2/12/2020 11:30 AM - During an observation, R53 was in the main activity room for an activity. R53's preference is "in room" activity environment.</p> <p>2/12/2020 12:20 PM - R53 was observed in her room seated in a recliner chair and crying out softly. The television was not within R53's view since it was blocked by the privacy curtain.</p> <p>2/13/2020 10:04 AM - During an observation, R53 was awake in bed and the television was off.</p> <p>The facility failed to honor R53's preference for watching television in her room on three random observations over two days.</p> <p>2. A review of R100's clinical record revealed:</p> <p>7/22/2011 - R100 was admitted to the facility with a brain injury and dementia.</p> <p>R100's activities care plan (last revised 1/6/20) included the following approaches: "Staff will support (R100's) environment by providing preferred in room activities of interest ... a past enjoyment with listening to music and enjoys movies as tolerated. Staff will encourage and assist (R100) with the Music and Memory individualized Ipod program with music of preference provided by daughter ... "</p> <p>1/7/2020 - An annual MDS documented that R100 had a preference of listening to music.</p>	F 679	<p>2. a. All residents that have a brain injury with severe dementia and who are bed bound are at risk of being affected.</p> <p>3. a. RCA determined that the center did not have an established minimum requirement for activity visits per day for brain injury with severe dementia and who are bed bound. The center has now implemented an activity of choice at a minimum, of two times per day for residents that have a brain injury with severe dementia and who are bed bound.</p> <p>b. The staff educator will educate the licensed nurse, C.N.A. and activity staff (who are responsible to provide and document)on the need to provide / offer an activity of choice at least two times per day for residents that have a brain injury with severe dementia and are bed bound.</p> <p>4. a. Activities Director / designee will do daily audits of 50% of all residents that have a brain injury with severe dementia and are bed bound to monitor that activities of choice are being provided / offered at least two time per day. b. The results of these audits will be reported out in monthly QA and will continue until a 100% compliance is achieved for 3 months.</p>		

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F 679	<p>Continued From page 15</p> <p>2/1/2020 - 2/12/2020 - R100's Daily Activity Participation record lacked evidence of engaging R100 in music activity.</p> <p>2/10/2020 2:38 PM - R100 was observed in bed, awake, with the television off and no music playing or any evidence of activity or stimulation.</p> <p>2/12/2020 10:40 AM - The facility offered residents a music activity in the main activity room and R100 was not in attendance.</p> <p>2/13/2020 9:50 AM - R100 was observed lying in bed with no noted activity of choice or external stimulation. R100 was looking at the wall.</p> <p>2/13/2020 1:22 PM - R100 was observed lying in bed awake, alert and staring at the wall. The lights and television were off and there was no music playing.</p> <p>2/17/2020 1:36 PM - During an observation and interview E20 (CNA) confirmed that R100 had no purposeful stimulation. E20 stated that when working, she had rarely seen the television on, and confirmed that R100 did not have any devices for music or movies in the room. E20 stated that R100 only got up out of bed on certain days of the week and added that "once in a while activity staff visits and will read or something to her." E20 confirmed that R100 needed more stimulation and would "have to look into that."</p> <p>Findings were reviewed with E1 (NHA), E2 (DON), E27 (Regional VP), E17 (Medical Director) and E18 (Corporate Nurse) on February 18, 2020 during the exit conference beginning at approximately 1:15 PM.</p>	F 679			

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F 686 F 686 SS=D	Continued From page 16 Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on review of clinical record, observation and interview it was determined that for one (R58) out of five residents reviewed for pressure ulcers, the facility failed to elevate heels to prevent pressure ulcers from developing. Findings include: 12/18/19 - A care plan problem for the potential for pressure ulcers (sore area of skin that develops when blood supply to it is cut off due to pressure) included the intervention to offload heels when in bed. 12/19/19 - A quarterly MDS documented R58 was totally dependent on staff for all care and had severely impaired cognition. During random observations, R58 was found laying flat on his back in bed with heels not offloaded (in contact with the mattress).	F 686 F 686	F686 1. R58's heels are now offloaded and the tutorial pictures for positioning are in place. There was no harm to any Resident. 2. a. Any resident that has an order for off loading has the potential to be affected. A full house sweep was conducted to monitor that residents heels were off loaded. Pillow inventory and par verified and staff educated on pillow location storage. b. Any resident that has a tutorial pictures for positioning are at risk. A whole house audit of residents that have pictures for positioning will be conducted and corrections will be made accordingly. Staff educated who to notify if picture(s) are missing.	4/17/20	

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F 686	<p>Continued From page 17</p> <p>- 2/10/2020: 11:29 AM. - 2/11/2020: 8:02 AM, 9:30 AM and 10:08 AM. - 2/12/2020: 9:01 AM and 12:13 PM. - 2/13/2020: 8:58 AM and 11:58 AM.</p> <p>2/17/2020 10:00 AM - During an interview, E20 (CNA) revealed that R58 should have had a pillow under his legs to elevate the feet. E20 pointed out that pillow(s) for offloading heels were not available in R58's room.</p> <p>2/17/20 10:10 AM - During an interview with E21 (CNA), it was revealed that there was a book with pictures to show how to position residents. It was further revealed that R58 had pictures for positioning but staff was unable to locate them.</p> <p>Findings were reviewed with E1 (NHA), E2 (DON), E27 (Regional VP), E17 (Medical Director) and E18 (Corporate Nurse) on February 18, 2020 during the exit conference beginning at approximately 1:15 PM.</p>	F 686	<p>3. a. RCA was the resident's point of care profile was not updated to include offloading, to assure inventory in room. Residents that have orders for offloading will now have their point of care profiles updated to include offloading this will allow staff easily identify these residents and assure inventory. b. The Staff Educator will educate all licensed nurses to update the resident's point of care profile for offloading when ordered. c. The Staff Educator will educate the C.N.A.'s to review residents point of care profile for offloading and remind where to locate inventory. d. RCA determined the center did not have a system for staff to communicate when tutorial pictures for positioning were missing. The staff Educator will educate licensed nurses and C.N.A.'s report to the Nursing Supervisor when the tutorial pictures for positioning are missing so they can be replaced. Picture replacement check-off added to supervisor rounds.</p> <p>4. a. The DON/designee will audit weekly the point of care profile of all residents that have orders for off loading for accuracy and verify inventory with environmental services. b The DON/designee will audit daily 10% of the residents that need to have their heels offloaded daily for compliance . d. The results of these audits will be reported out in monthly QA and will continue until a 100% compliance is achieved for 3 months. d. The DON/designee will audit</p>		

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F 686	Continued From page 18	F 686			
F 690 SS=D	<p>Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3)</p> <p>§483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.</p> <p>§483.25(e)(2) For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-</p> <p>(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;</p> <p>(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and</p> <p>(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.</p> <p>§483.25(e)(3) For a resident with fecal</p>	F 690	<p>weekly that residents that have picture of positioning are in the place and that any request for missing picture were replaced timely. e. The results of these audits will be reported out in monthly QA and will continue until a 100% compliance is achieved for 3 months.</p>	4/17/20	

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F 690	<p>Continued From page 19</p> <p>incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview it was determined that for one (R43) out of three residents investigated for falls, the facility failed to develop and implement a toileting plan. Findings include:</p> <p>Review of a facility policy entitled Bowel and Bladder Management (effective 5/5/17) found that ..."Upon completion of the bowel and bladder evaluation, a plan of care will be developed. This plan of care may include a bladder retraining program (toileting program) ..."</p> <p>Review of R43's clinical record revealed:</p> <p>9/7/17 - R43 was admitted to the facility and a care plan for urinary incontinence was developed.</p> <p>1/29/18 - The care plan for safety hazard to self as evidenced by transferring (getting up from bed or chair) without assistance included an approach to "assess for possible causes of behavior (i.e., pain, toileting needs, repositioning needs, confusion, agitation) and correct if possible."</p> <p>8/27/19 - The intervention for "toileting program" was added to R43's urinary incontinence care plan.</p> <p>9/5/19 - The significant change MDS assessment documented that R43 had moderate cognitive</p>	F 690	<p>1. R43 toileting plan is now in place.</p> <p>2. a. All residents that have been transferred between units have the potential to be at risk. b. All residents that have toileting plans will be audited to monitor that they are in place. Corrections will be made accordingly.</p> <p>3. a. The facility determined that the RCA was a lack of a unit to unit transfer checklist to monitor that all pieces of the resident's medical record was transferred with the patient. The facility developed a unit to unit transfer form to monitor that all pieces of the resident's record has been transferred with the resident including toileting plans. b. The staff educator will educate the licensed nursing staff on the unit to unit transfer form.</p> <p>4. a. The DON/designee will audit weekly all residents that have been transferred from unit to unit to monitor that the toileting plan was transfer and is in place. b. The results of these audits will be reported out in monthly QA and will continue until a 100% compliance is achieved for 3 months.</p>	

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F 690	<p>Continued From page 20</p> <p>impairment (forgetful, poor decision-making), needed limited assistance of one staff person for transferring, extensive assist of one staff for toileting, was occasionally incontinent of urine and on a toileting plan.</p> <p>11/20/19 - R43 returned to the Sussex unit after a couple months on the Lewes unit.</p> <p>11/27/19 - A quarterly MDS assessment included that R43 was still occasionally incontinent of urine and on a toileting plan but now needed extensive assistance with two staff to transfer.</p> <p>11/27/19 - 11/29/19 - Review of the bowel and bladder evaluation revealed an incomplete assessment: missing 3-11 shift on 11/29/19; and several sections were blank: Step 5 (type of incontinence) and Step 6 (type of bladder program assigned based on assessment). E5 (RN, UM) wrote "cont B&B" (continue bowel and bladder program) and signed and dated the form on 2/17/2020, almost two months after the 72 hour voiding diary end date.</p> <p>12/11/19 - The care plan for urinary tract infection related to retention (inability to empty all urine from the bladder) included an approach "toileting as ordered and encourage complete emptying of bladder."</p> <p>2/14/2020 (9:27 AM) - After review of the paper chart revealed no toileting plan, during an interview, E7 (RN) stated the toileting plan would be on colored paper. E7 looked in the chart and said, "The only ones in the chart are blue, and they (blue ones) are for behaviors." E7 confirmed the lack of a toileting plan in R43's clinical record.</p>	F 690			

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F 690	Continued From page 21 2/14/2020 (11:15 AM) - During an interview, E5 (RN, UM) explained that R43's toileting plan did not transfer with the resident when R43 returned from the Lewes unit. February 2020 - Review of CNA documentation showed that R43 remained occasionally incontinent of urine. 2/17/2020 - During an interview, E19 (CNA) stated that R43 had been going by herself to the bathroom every "30 minutes to an hour." E19 added that R43 would "forget she had already gone" and go back into the bathroom. R43 did not call for assistance with transfer / standing up, but pressed the call bell once in the bathroom. Findings were reviewed with E1 (NHA), E2 (DON), E27 (Regional VP), E17 (Medical Director) and E18 (Corporate Nurse) on February 18, 2020 during the exit conference beginning at approximately 1:15 PM.	F 690			
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the	F 693		4/17/20	

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F 693	<p>Continued From page 22 resident; and</p> <p>§483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, review of the clinical record, and review of a facility policy, it was determined that for one (R100) out of one sampled resident reviewed for enteral feeding, the facility failed to label an enteral feeding bag formula when opened to prevent complications from expired formula. Findings include:</p> <p>A facility competency/policy (undated) entitled Enteral Feeding Pump Clinical Performance Evaluation Checklist included: "Label formula container with date, rate, and resident name."</p> <p>Review of R100's clinical record revealed:</p> <p>7/22/2011 - R100 was admitted to the facility with a brain injury.</p> <p>3/4/2018 - A physician's order included the enteral feeding formula (liquid nourishment) to be given through a tube placed through the abdomen into the stomach.</p> <p>1/7/2020 - An annual MDS documented that R100 was not to have anything by mouth and received all nutrition from an enteral feeding formula.</p>	F 693	<p>1. R 100's tube feeding container is now labeled with the resident's name , date and time it was opened.</p> <p>2. a. All residents that have are tube fed have the potential to be affected. b. A whole house audit of all residents that have tube feedings was conducted to audit that the enteral container was labeled for residents name, date and time it was opened. Corrections will be made upon discovery.</p> <p>3. a. RCA determined there was a lack of a tracking system to monitor the labeling of enteral containers. The electronic order for all tube feeds will be put into an EMR alert so staff must sign off that they label enteral container with residents name, date and time opened. The EMR will required this process each time to complete the order.</p> <p>b. The Staff Educator will educate the licensed nurses on the new electronic tracking system for tube feeding containers and the need to document all these components directly on the tube</p>	

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F 693	Continued From page 23 2/10/2020 2:41 PM - An observation in R100's room revealed that R100 was in bed, and hanging next to the bed was an approximately half empty bag of enteral feeding formula with tubing attached. The container was not labeled with the name of the resident, date and time that it was opened. 2/10/2020 2:46 PM - During an observation and interview with E26 (LPN) it was confirmed that the bag of enteral feeding formula lacked a name, date and time of when it was opened. E26 confirmed that the formula was only able to be administered for up to twenty-four hours after it was opened. E26 also confirmed that the expiration date/time would not be known without the date and time that it was opened written on the container. 2/14/2020 2:35 PM - During an interview E3 (ADON) confirmed that the only policy for enteral feeding was a Clinical Performance Evaluation Checklist. E3 confirmed that the checklist / policy lacked timing the bag of enteral formula to determine when the twenty-four-hour expiration time was reached. E3 confirmed that there was a place on the formula bag to write the time and that the expectation was for it to be correctly labeled. Findings were reviewed with E1 (NHA), E2 (DON), E27 (Regional VP), E17 (Medical Director) and E18 (Corporate Nurse) on February 18, 2020 during the exit conference beginning at approximately 1:15 PM.	F 693	feeding container . 4. a. The DON/designee will audit daily the enteral container of all residents being tube feed to monitor that the enteral container is labeled with the residents name , the date and time it was opened. b. The DON/designee will conduct an audit of the EMR to monitor that alert system to staff to label enteral containers is being utilized correctly . b. The results of these audits will be reported out in monthly QA and will continue until a 100% compliance is achieved for 3 months.		
F 697 SS=D	Pain Management CFR(s): 483.25(k)	F 697		4/17/20	

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F 697	<p>Continued From page 24</p> <p>§483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review and interview it was determined that for one (R91) out of one resident reviewed for pain management the facility failed to assess and treat pain during a procedure / treatment. Findings include:</p> <p>The following was observed, and the clinical record was reviewed for R91:</p> <p>7/5/19 - A care plan (last reviewed on 1/1/2020) for the potential for pain included a goal that pain would be controlled and acceptable to the resident.</p> <p>8/13/19 - The physicians' orders included to "evaluate pain using a verbal pain rate ... pain level of 0 out of 10 twice daily." The 0 to 10 verbal pain scale was a rating of pain severity stated by the resident on a 0 to 10 scale with 0 meaning no pain and 10 meaning the worst pain.</p> <p>10/6/19 - A physician's order included a pain medication that could be administered every six hours as needed for pain.</p> <p>12/31/19 - A significant change MDS documented that R91 was severely cognitively impaired and did not exhibit any behavioral (verbal or physical aggression including yelling) symptoms or rejection of care.</p>	F 697	<p>1. a. R91's pain care planned was updated to include interventions for the use of a pain scale prior to and during treatments: requiring assessing and treatment of pain.</p> <p>2. a Pain care plans for all residents that have dressing changes will be will reviewed by DON/designee to monitor for interventions to assure that each occurrence assess for pain prior to treatment, during treatment, and after treatment. T</p> <p>3 a. RCA determined that nursing treatment regimes did not systemically include interventions to assess the resident for pain prior, during and after treatments on pain care plans. Now nursing will add these interventions to pain care plans and correspond to the treatment itself. d. Staff Educator will educate licensed nurses to include interventions to assess the resident for pain prior, during and after treatment on their pain care plans.</p> <p>4. a. The DON/designee will audit weekly the pain care plans for all residents that have orders for a dressing change to monitor that they include interventions to assess for pain prior, during and after treatment. b. DON / designee will observe 25% care planned Residents with pain will</p>	

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F 697	Continued From page 25 Care plans for skin (dated 1/9/2020, 1/17/2020, and 1/21/2020) document that R91's skin was fragile. 2/14/2020 2:15 PM - During an observation of pressure ulcer treatment, R91 stated three times, "Don't do that it hurts." E13 (LPN) hesitated twice and asked R91 if she was okay but continued to peel off the dressing. R91 was not assessed for the pain severity or offered pain medication. 2/14/2020 2:28 PM - An interview with E14 (CNA) revealed that R91 was fearful of being moved around and would tense up and cling to staff when being repositioned. 2/14/2020 2:30 PM - An interview with E13 (LPN) revealed that she assessed R91's pain off and on all day. Pain was checked when R91 was put in bed, in the chair and when repositioned. E13 stated R91 did holler out often, and it was a behavior. E13 acknowledged that R91 was very scared during repositioning and when getting in and out of the bed/chair. E13 (LPN) did not identify the severity of R91's pain when R91 said, "Don't do that it hurts" nor was the treatment stopped to provide R91 with medication for pain. Findings were reviewed with E1 (NHA), E2 (DON), E27 (Regional VP), E17 (Medical Director) and E18 (Corporate Nurse) on February 18, 2020 during the exit conference beginning at approximately 1:15 PM.	F 697	be observed at least weekly for compliance with assessment before, during, and after at least one time per week for compliance. b. The results of these audits will be reported out in monthly QA and will continue until a 100% compliance is achieved for 3 months.		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2)	F 725		4/17/20	

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F 725	<p>Continued From page 26</p> <p>§483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).</p> <p>§483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides.</p> <p>§483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on interview, observation, and review of other facility documents, it was determined that the facility failed to ensure sufficient staffing levels of CNAs to man the dining room and meet the residents needs to eat in a group setting in the dining room. Findings include: 9/4/2019 - A document entitled Resident Menu Committee Minutes (the section for Concerns / Suggestions) included: "Don't like it when the</p>	F 725	<p>1. The residents concerns regarding the closing of section of the dining room reserved for independent dining for lunch and dinner meals has been brought through the center's QAPI. All meals and snacks have been provided to all residents, regardless of location, no weight loss noted by any Resident who participates in the program. Under CMS emergency regulations on March 13, 2020</p>		

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F 725	<p>Continued From page 27 dining room is closed."</p> <p>Resident Council Meeting minutes (under dietary - old business) included: - 11/12/2019: "Residents would like to be notified when the dining room is closed. They like to eat in the dining room and would like it to be open." - 12/10/2019: "Many residents complained that the dining room continues to be closed and they enjoy being in the dining room and would like to have it open." - 1/7/2020: "Many residents complained that the dining room continues to be closed and they enjoy being in the dining room and would like to have it open."</p> <p>2/10/2020 11:00 AM - During an interview, AR1 (Anonymous Resident) complained that the dining room in the activities area frequently closes and this is a spot that residents like to go to to socialize during meals.</p> <p>2/11/2020 9:30 AM - E5 (RN, UM) was heard saying to staff, "We have to close the dining room today."</p> <p>2/11/2020 10:34 AM - During a Resident Council Meeting attended by a state and federal surveyor, several residents voiced concerns regarding short-staffing. The residents explained that they like to be in the dining room for meals and that the staffing shortage causes the dining room to be closed down.</p> <p>Although there was a common thread of resident concerns from September 2019 through February 2020 meeting minutes regarding the closing of the dining room for meals, the QAPI / Facility</p>	F 725	<p>all communal dining programs were cancelled in all nursing homes in the country.</p> <p>2. All residents that are approved to partake in the independent dining room program for lunch and dinner have the potential to be affected.</p> <p>3. a. RCA determined that there was inconsistency in the method of providing timely communications with program participants based on call-outs and triage of staff above ratios to provide the extra programming. Once communal dining is permitted by CMS, the independent dining room program will be open for lunch meals, Monday through Friday. Dining room space and meals are always available for all Residents. During the cessation of all communal dining in every nursing home in the country, the center will create a written program that provides the guidelines and expectations of the independent dining program for its participants based on historical regulations, verifying that participants are aware of the program and its changes. A written notification of this action will be sent to all participants as soon as possible, and will be reintroduced at the next Resident Council and Chow Chat. Additionally the center did not have a mechanism to recognize repeat dissatisfaction comments by individuals at Resident council, even though Resident Council voted or verified, by majority, the programs process. Monthly QAPI meetings will provide an extra review of</p>		

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F 725	Continued From page 28 Review (annual review of general resident needs and facility) provided to the state survey team lacked evidence of determining residents' concerns or how concerns were being addressed. 2/12/2020 4:35 PM - An observation of R19 and R94 asking E22 (LPN) if the dining room was going to be open tonight. 2/12/2020 4:39 PM - During an interview with E22 (LPN) revealed that the dining room is "closed when there is not enough staff (CNA) to supervise the residents." 2/17/2020 1:00 PM - During an interview with E25 (Activity Aide), E23 (Activity Aide) and E24 (Activity Aide), all three activity aides identified that the dining room was closed when there were not enough CNAs since there had to be a CNA in the dining room for safety. E24 added that the residents hated when the dining room was closed. Findings were reviewed with E1 (NHA), E2 (DON), E27 (Regional VP), E17 (Medical Director) and E18 (Corporate Nurse) on February 18, 2020 during the exit conference beginning at approximately 1:15 PM.	F 725	outlier comments as compared to grievances by Activities and Social Services Staff, in order to capture those who have concerns missed by majority approval. b. The administrator will address the resident council and all newly assessed independent dining program participants (based on historic and potential new communal dining procedures from CMS) prior to re-start of communal dining programs by CMS. c. All future Resident council meetings and chow chats will have a designated segment on unresolved individual and group concerns that are stated as unresolved, not just old business. 4. a. The administrator/designee will verify that all new or renewed Residents for the Independent Dining program have been educated about the above changes to the program and that a care plan is reflective of the participation. b. The administrator / designee will compare the QAPI meeting notes with Resident Council minutes, Chow Chat minutes and Grievances monthly to find any missed repeated concerns. b. The results of these audits will be reported out in monthly QA and will continue until a 100% compliance is achieved for 3 months.		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs.	F 758		4/17/20	

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F 758	<p>Continued From page 29</p> <p>§483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:</p> <ul style="list-style-type: none"> (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic <p>Based on a comprehensive assessment of a resident, the facility must ensure that---</p> <p>§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;</p> <p>§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;</p> <p>§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and</p> <p>§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and</p>	F 758		
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F 758	<p>Continued From page 30 indicate the duration for the PRN order.</p> <p>§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and record review it was determined that for one (R18) out of five residents reviewed for unnecessary medications, it was determined that the facility failed to document an adequate indication for an antipsychotic (drug to treat psychosis and other mental/emotional conditions). Findings include:</p> <p>A review of R18's clinical record revealed:</p> <p>8/8/2019 - R18 was admitted to the facility with dementia and a history of a stroke.</p> <p>2/14/2020 - A physician's order included that an antipsychotic medication was to be administered once a day for "unspecified dementia with behavioral disturbance." Dementia with behavioral disturbance is not an appropriate indication for the use of antipsychotic medications.</p> <p>A review of R18's clinical record including physician and nursing progress notes as well as psychiatric (mental health) consult notes lacked evidence that R18 experienced psychotic features, hallucinations, or delusions or an appropriate diagnosis to warrant the administration of an antipsychotic medication.</p> <p>2/18/2020 8:29 AM - During an interview E3</p>	F 758	<ol style="list-style-type: none"> 1. R18 is on a gradual dose reduction of his antipsychotic medication with the goal to eliminate or lowest dose as determined by psychiatrist/ psychiatric nurse practitioner and in coordination with attending physician. 2. a. All residents that are ordered an antipsychotic medication and do not have the appropriate diagnosis have the potential to be affected. B. A whole house audit of residents on antipsychotic medication will be conduct to audit for appropriate diagnosis or the resident has a risk benefit note from the psychiatric NP and/or psychiatric that includes the appropriate indication for use for the drug documented. Any medications used without proper diagnosis will be reviewed by the DON/ designee with the attending physician and psychiatrist / psychiatric nurse practitioner for appropriated changes and notifications to required parties. 3. a. RCA determined there was a lack of communication from nursing to the Psychiatric NP/psychiatrist regarding residents that did have the appropriate diagnosis for the medication. The facility developed a system where the 		

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F 758	Continued From page 31 (ADON) confirmed that his review of the clinical record revealed lack of an appropriate diagnosis for R18's antipsychotic medication. Findings were reviewed with E1 (NHA), E2 (DON), E27 (Regional VP), E17 (Medical Director) and E18 (Corporate Nurse) on February 18, 2020 during the exit conference beginning at approximately 1:15 PM.	F 758	DON/designee will communicate in writing to the Psychiatric NP/psychiatrist any resident that does not have the proper diagnosis for an antipsychotic medication. Any resident that is on an antipsychotic without the appropriate diagnosis will now have a risk benefit note from the psychiatric NP and/or psychiatrist to include the indication for the medication and verified by attending and/or Medical Director. b. DON educate the psychiatric NP, psychiatrist, and attendings on the new requirement. 4. a. The DON/designee will audit monthly all residents on antipsychotic drug for either an appropriate diagnosis or a risk benefits note from either the psychiatric NP and/or psychiatrist's which includes the indication for the drugs use. b. The results of these audits will be reported out in monthly QA and will continue until a 100% compliance is achieved for 3 months.		
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet	F 791		4/17/20	

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F 791	<p>Continued From page 32</p> <p>the needs of each resident:</p> <p>(i) Routine dental services (to the extent covered under the State plan); and</p> <p>(ii) Emergency dental services;</p> <p>§483.55(b)(2) Must, if necessary or if requested, assist the resident-</p> <p>(i) In making appointments; and</p> <p>(ii) By arranging for transportation to and from the dental services locations;</p> <p>§483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay;</p> <p>§483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and</p> <p>§483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and record review it was determined that for one (R61) out of one resident sampled for dental review, the facility failed to provide routine dental services. Finding include:</p> <p>11/17/16 - A physician's order documented</p>	F 791	<p>1.) R61 was scheduled for the first available appointment by dentist, early March 2020.</p> <p>2.) All long term care Residents who have requested annual dental check-ups have</p>		

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F 791	<p>Continued From page 33</p> <p>"Resident may be seen by...dentist...prn."</p> <p>10/18/19 - A dental care plan documented that R61 "has impaired dentition ... (Broken teeth)" with an approach to "arrange for dental consult as needed."</p> <p>12/9/19 - A quarterly MDS revealed that R61 had "obvious or likely cavity or broken natural teeth" and R61 had a BIMS of 14 (alert, oriented, cognitively intact).</p> <p>12/9/19 - A facility "Oral Cavity Observation" documented that the condition of R61's teeth and gums were not broken, loose and R61 did not have carious teeth.</p> <p>2/10/2020 - During an interview, R61 stated that R61 chipped a tooth while living at the facility. R61 stated that dental services were not available. When asked about routine visits, R61 stated that R61 had never had a routine dental visit while living in the facility.</p> <p>2/17/2020 9:10 AM - During an interview E3 (ADON) revealed that R61's last dental exam was in 2018. E3 explained that dental reviews are performed during oral observations done by nursing, quarterly. Referrals are then made if requested or necessary.</p> <p>2/17/2020 11:45 AM - During an interview, E9 (SWA) explained that medical records staff schedules the residents' dental visits. E33 (Medical Records) explained that a company comes to the facility once a month to perform dental services. E33 said nursing sends the resident's request to medical records. Services are available for any resident requesting a visit.</p>	F 791	<p>the potential to be affected. A whole house audit was conducted if any Resident had requested a routine check-up in the past twelve months without any consult or service.</p> <p>3.) RCA determined that though the center actively promotes at least monthly dental appointment services for on-site dental work the center took the declination of the protected (no-cost to Resident) dental plan as a declination for services. Facility has generated a quarterly care plan tool to verify with Resident the declination of dental protection versus the declination of routine dental services, tool educates Resident and/or Responsible party on pricing and services, and what the facility will cover if no funds are available. Emergency services, as verified with R61 and all other Residents reviewed for the past twelve months were provided timely.</p> <p>4.) Administrator and Social Services Director and/or Designee will audit all monthly long-term care plan meetings for the use of the new dental services tool and the scheduling of services. b. The results of the audits will be reported in monthly QA until a 100% compliance is achieved for three months.</p>		

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F 791	<p>Continued From page 34</p> <p>2/17/2020 12:50 PM - During an interview, R61 stated that R61's tooth has been broken for 1 1/2 years and R61 does not recall quarterly oral exams performed by nursing where R61 was offered professional dental services available at the facility.</p> <p>2/17/2020 2:07 PM - During an interview, E2 (DON) stated that dental cleanings and assessments are available for all Medicaid patients. Every Medicaid patient is referred to receive dental services.</p> <p>2/17/2020 2:53 PM - E2 (DON) confirmed that R61 was not provided dental services in 2019.</p> <p>2/17/2020 3:30 PM - Findings were reviewed with E1 (NHA), E2 (DON), E27 (Regional VP), E17 (Medical Director) and E18 (Corporate Nurse).</p> <p>2/17/2020 3:30 PM - E1 (NHA) confirmed that dental services are offered. Each year all residents or resident representatives receive a letter explaining the benefits offered. To receive services, they must fill out an application. For Medicaid residents the funds for the insurance are deducted from the fee being paid to the facility, not the residents personal funds. E1 remembered that R61 consistently does not accept these services. E1 stated that R61 or R61's representative did not complete an application for services.</p> <p>There was no evidence that R61 or R61's representative received the dental insurance letter, nor that they refused the services.</p> <p>Findings were reviewed with E1 (NHA), E2</p>	F 791			

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F 791	Continued From page 35 (DON), E27 (Regional VP), E17 (Medical Director) and E18 (Corporate Nurse) on February 18, 2020 during the exit conference beginning at approximately 1:15 PM.	F 791			
F 810 SS=D	Assistive Devices - Eating Equipment/Utensils CFR(s): 483.60(g) §483.60(g) Assistive devices The facility must provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals and snacks. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observations and interview, it was determined that for one (R135) out of one sampled resident investigated for ADLs (activities of daily living), the facility failed to assist with feeding as needed and monitor for changes in ability to eat, as per the plan of care. Findings include: A review of R135's clinical record revealed: 10/4/2018 - R135 was admitted to the facility. 2/11/2020 - The last revision of R100's care plan for self-care deficit related to decrease in functional mobility, strength, balance and endurance included the following approaches: "For all meals, built-up utensils and scoop dish. Assist with feeding if needed, i.e. set up trays for meals, provide verbal cues, place utensils in hand, guide utensils to mouth, etc. Monitor to ensure adequate intake of food and fluids. Encourage independence with ADLs. Provide assistance as needed. Provide assistive adaptive	F 810	1. R135 no longer resides in the facility. 2. a. All residents that require extensive assistance with eating and use adaptive equipment have the potential to be affected. b. All residents that trigger on the MDS for extensive assistance with feeding will have a therapy screen initiated by the MDS coordinator to monitor the appropriateness of the resident's current or needed adaptive equipment . 3. a. The RCA determined there was a lack of a communication trigger that initiated a therapy screen when a resident triggers for an onset of extensive assistance with feeding with or without prior use of adaptive equipment. Upon completion of the whole house audit, when a resident triggers on their MDS for extensive assistance for feeding the MDS coordinator initiated a therapy screen regardless of devices b. The RCA also determined a lack of a system that prompted staff to initiate	4/17/20	

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F 810	<p>Continued From page 36</p> <p>equipment as ordered/indicated. Monitor for and report significant changes in ADLs or cognitive status to physician, nursing, and family."</p> <p>1/17/2020 - A quarterly MDS documented that R135 had a BIMs of 10 (moderately impaired thinking ability) and needed (1) supervision, oversight, encouragement, cueing with eating and the (2) physical assistance of one person for eating (more than just setup of tray).</p> <p>2/10/2020 12:15 PM - R135 was observed reclining in bed with the head of the bed up approximately 70 degrees. The lunch tray was on the over the bed table straddling her lap. She was holding a bowl of soup in one hand. With the other hand R135 was dipping all her fingers in the soup bowl then licking them. There was spilled food staining her gown. When asked why she was not using the built-up utensils on her tray, R135 stated that she could not use them.</p> <p>2/10/2020 12:30 PM - During an interview, E34 (R135's CNA) was asked how much assistance does resident need to eat. E34 replied that she likes to be independent. When asked how much of her meal does R135 usefully eat, E34 replied about 20 - 25 percent.</p> <p>2/12/2020 12:30 PM - R135 was observed reclining in bed with the head of the bed up. The lunch tray was on the over the bed table straddling her lap. There was food spilled on her gown. When asked how your lunch was, she replied, "Well I'm wearing it. I love soup, but it is too hard to eat it." Three unused utensils (spoon, fork and knife) with built up handles were on her tray.</p>	F 810	<p>therapy screens when residents were observed not using their adaptive equipment and/or increase spillage. Staff Educator will educate the licensed nursing staff and the C.N.A.'s to initiate a therapy screen when a resident is not utilizing their adaptive equipment appropriately , or if the resident has increase of spillage.</p> <p>4. a. Therapy/designee and MDS will do a weekly audits on 25% residents that have new orders for adaptive equipment to monitor for the appropriateness use of their adaptive equipment. ADON / designee will perform weekly audits on reports of spillage and observe 10 extensive assistance for feeding Residents to collaborate reporting / screening of spillage and/or difficulties with adaptive equipment. b. The results of these audits will be reported out in monthly QA and will continue until a 100% compliance is achieved for 3 months.</p>		

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F 810	<p>Continued From page 37</p> <p>2/13/2020 12:40 PM - R135 was observed reclining in bed with the head of the bed up. The lunch tray was on the over the bed table straddling her lap. R135 was holding a bowl of soup to her lips with both hands trying to sip the soup, but it was spilling on her gown. When asked to try to use the built-up handled spoon on her tray, she was unable to grip it or pick it up off the tray. When the spoon was placed in R135's hand she was unable to turn it in a manner to allow her to eat the soup. There was a two-handed sippy cup containing juice that she was able to drink from, but not a cup for the soup. R135 stated that she would like staff to assist her in eating because she has become weaker and cannot pick up the spoon or fork herself.</p> <p>2/17/2020 1:42 PM - During an interview, E35 (RD) stated she has been monitoring R135's weight loss and food preferences and last saw her on 2/4/2020. E35 revealed soup was a food preference, but occupational therapy would address her ability to feed herself (not dietary).</p> <p>2/17/2020 2:00 PM - During an interview, E36 (Rehab Director) stated that the occupational therapists last worked with R135 in November 2019, at that time she was able to feed herself with minimal to no spillage using the adaptive equipment, and therapy has not received a request from nursing to re-evaluate her.</p> <p>2/17/2020 2:30 PM - During an interview, E5 (RN, UM) stated she was not aware that R135 was having difficulty with eating and she relies on the MDS nurses or CNAs to notify her of concerns or changes.</p> <p>Findings were reviewed with E1 (NHA), E2</p>	F 810		

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F 810	Continued From page 38 (DON), E27 (Regional VP), E17 (Medical Director) and E18 (Corporate Nurse) on February 18, 2020 during the exit conference beginning at approximately 1:15 PM.	F 810			
F 812 SS=D	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 by: Based on observation and interview it was determined that the facility failed to store food in accordance with professional standards by storing expired juice and supplements. Findings include: 1. 2/12/2020 4:10 PM - An observation was made in the Henlopen unit nourishment room of 26 liquid supplements being stored with an expiration date of 11/7/19. During an interview at	F 812	1. a. The expired supplements on the Unit have been discarded. b. The open and undated box of pre-thickened cranberry juice on the Unit has been discarded. 2. a. All residents that have supplement ordered have the potential to be affected. b. A whole house audit of supplements will be conducted by DON/designee and any expired supplements will be	4/17/20	

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F 812	Continued From page 39 the same time, E36 (RN) confirmed the observation and prepared to dispose of the supplements. 2/17/2020 3:30 PM - Finding was reviewed with E1 (NHA), E2 (DON), E27 (Regional VP), E17 (Medical Director) and E18 (Corporate Nurse). 2. 2/12/2020 (8:17 AM) - During a random observation of the Lewes unit nourishment refrigerator revealed an open and undated box (container) of pre-thickened cranberry juice. 2/12/2020 (11:45 AM) - During an interview E4 (LPN, UM) confirmed the pre-thickened juice was good for 24 hours after opening and confirmed the opened container in the refrigerator was not dated / timed. E4 immediately discarded the undated container. Findings were reviewed with E1 (NHA), E2 (DON), E27 (Regional VP), E17 (Medical Director) and E18 (Corporate Nurse) on February 18, 2020 during the exit conference beginning at approximately 1:15 PM.	F 812	discarded. c. Any resident that has an order for thickened liquids has as the potential to be affected. d. A whole house audit will be conducted by DON/designee of all nourishment refrigerator will be conducted by DON/designee any foods not labeled properly will be discarded. 3. a. The RCA was determined that expiration date on supplements and check for correct labeling of food in the nourishment refrigerators was not included on the IDT environmental infection control checklist. Checking for the expiration date on supplements and to check all nourishment refrigerators for any undated and/or unlabeled food has been added to the IDT environmental infection control checklist. b. The Staff Educator will educate the IDT team and the licensed nurses how to conduct the new infection control rounds. 4. a. Currently the IDT is doing infection control rounds every shift. The DON/designee will do a weekly comparable infection rounds to monitor the accuracy of the daily infection control rounds being conducted by the IDT. b. The results of these audits will be reported out in monthly QA and will continue until a 100% compliance is achieved for 3 months.		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program	F 880		4/17/20	

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F 880	<p>Continued From page 40</p> <p>designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.</p> <p>§483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:</p> <p>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv) When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the</p>	F 880			

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

PRINTED: 09/25/2020
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 02/18/2020
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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F 880	<p>Continued From page 41</p> <p>least restrictive possible for the resident under the circumstances.</p> <p>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and</p> <p>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of facility policy and procedures, it was determined that the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the transmission of communicable diseases and infections. A tour of the laundry facilities revealed the facility failed to prevent contamination of clean laundry. The facility's only lab specimen refrigerator was located in a clean area. Additionally, for one (R197) out of two sampled residents for isolation precautions, the facility failed to ensure that appropriate contact precautions were followed. Findings include:</p>	F 880	<p>1. a. Once informed by surveyor the door between the soiled and clean linen room was left open, with staff present, it was closed and signage placed on both sides of the door. b. Once informed by the surveyor, the individually wrapped par inventory of new mop heads and rags were stored on a shelf in the soiled linen room, all items were removed from the metal shelf in the dirty linen room and rewashed before putting back into inventory storage in a clean linen room. c. Once informed by the surveyor the only specimen refrigerator, stored in the same clean room for the past 20 years, should</p>	

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F 880	<p>Continued From page 42</p> <p>1. Laundry Inspection:</p> <p>2/14/2020 12:45 PM - 1:15 PM - An observation of the laundry revealed:</p> <p>a. The door between the dirty linen room (washer) and the clean linen room (dryer) was open. E28 (Laundry Worker) was present in the clean linen room. Several other staff entered the clean laundry room, but none recognized the open door between the soiled linen room and the clean linen room.</p> <p>b. Multiple clean housekeeping rags and mop pads were stored on a metal shelf in the dirty linen room (washer). During this observation, E29 (Housekeeper) entered the dirty linen room and took several clean mop pads to clean floors.</p> <p>2/14/2020 1:00 PM - During an interview, E30 (Laundry Manager) confirmed the above findings.</p> <p>2. Specimen Refrigerator:</p> <p>2/18/2020 9:00 AM - Observation of a specimen refrigerator on the Lewes unit in the nurses' station. The Lewes Nurses' station was a locked area that also contained the resident nourishment storage (refrigerator, microwave oven and sink) and the refrigerator for staff food.</p> <p>2/18/2020 9:05 AM - During an interview, E7 (LPN, charge nurse) stated that all of the facility's lab specimens were stored in this refrigerator.</p> <p>The facility's only lab specimen refrigerator was located in a clean area.</p>	F 880	<p>be stored in a soiled room, a new refrigerator was purchased for size and safety for a new location and placed in a soiled utility room, permanently. d. Once informed by the surveyor, the SLP was educated that precautions do pertain to her specific form of treatment and for herself. Therapy director verified that SLP had completed annual I.C training, however all therapy staff were educated immediately on C. Diff precautions.</p> <p>2. All residents have the potential to be affected.</p> <p>3. a. RCA determined that there was not a door close alert signage for the specific door and that infection control rounds did not include checking that specific door, though other doors were listed. The specific door cited was added to rounds. b. RCA determined that metal shelf on wall, though clearing all soiled containers, should not be used for any sealed inventory or extra par levels of inventory. Though HSCG policy is to wash all new items before first use, the shelving was permanently removed and no storage of anything except soiled items and related sealed chemicals will remain in room to avoid the risk of contamination. c. RCA determined that since specimens were collected in double bags before refrigeration, the specimen refrigerator has remained in the same location for many previous years and inspections. Recognizing a best practice opportunity, new refrigerator purchased and placed in soiled utility room for specimen holding d.</p>		

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F 880	<p>Continued From page 43</p> <p>3. Transmission-Based Precautions:</p> <p>The facility policy entitled "Isolation - Categories of Transmission-Based Precautions" last revised in October 2018 stated " ... Transmission-based precautions are additional measures that protect staff, visitors and other residents from becoming infected ... When a resident is placed on transmission-based precautions, appropriate notification is placed on the room entrance door ... so that personnel and visitors are aware of the need for and type of precaution. The signage informs the staff of the type of CDC precautions, instructions for use of PPE " The policy described that "Contact Precautions may be implemented for residents known or suspected to be infected with microorganisms that can be transmitted (spread) by direct contact with the resident or indirect contact with environmental surfaces or resident care items in the resident's environment ... Staff and visitors will wear gloves ... when entering the room ... Gloves will be removed and hand hygiene performed before leaving the room. Staff and visitors will wear a disposable gown upon entering the room and remove before leaving the room"</p> <p>2/5/2020 - R197 arrived at the facility with admitting diagnosis of Clostridium Difficile ("C-diff") for which he will receive antibiotic treatment.</p> <p>2/5/2020 - A doctor's order reflected "Maintain contact isolation for C-diff."</p> <p>2/14/2020 at 12:58 PM - E11 (SLP) was observed in R197's room sitting on the spare bed. E11 was not wearing gloves or a gown. When E11 exited the room, the surveyor asked if R197 was still on</p>	F 880	<p>RCA determined that though SLP had been through annual training, SLP interpreted specific treatment as a non-contact treatment and therefore did not use precautions. Education provided that though the treatment may not be contact, there is no guarantee that emergency contact could occur, therefore regardless of treatment description, transmission precautions must be followed. SLP and therapy staff immediately educated on TBP. Additionally the facility IP who maintains the master TBP and line listing list will provide the rehab department the list of all residents that are on precautions on a continuous basis.</p> <p>4. a. The DON/designee will do a weekly comparable infection rounds to monitor the accuracy of the daily infection control rounds being completed to items newly added for compliance. b. The Rehab Director will audit up to ten treatments weekly performed on any Resident with a TBP for PPE compliance. c. The housekeeping director and/or designee will perform ten observations weekly to assure that the door remains closed and there is no storage of par inventory in soiled linen room. The results of these audits will be reported out in monthly QA and will continue until a 100% compliance is achieved for 3 months.</p>		

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F 880	<p>Continued From page 44</p> <p>contact precautions, noting that the contact precaution signage and appropriate PPE were still hung at the room's entrance. E11 responded that they (precautions) did not apply to her because she does not "change him." The surveyor explained to E11 that C-diff spores are everywhere (door knobs, privacy curtains, bedside tables, etc.) and are easily spread, such that anyone who entered the room needed to wear PPE.</p> <p>According to the CDC, when "C. diff germs are outside the body, they become spores. These spores are an inactive form of the germ and have a protective coating allowing them to live for months or sometimes years on surfaces ... they become active again if swallowed and reach the intestines ... if your immune system is weakened or you've recently taken antibiotics, you could get sick." (https://www.cdc.gov/cdiff/prevent.html)</p> <p>2/14/2020 1:10 PM - During an interview with E12 (LPN), the surveyor informed her that E11 (SLP) had been in R197's room with no PPE.</p> <p>2/14/2020 - approximately 1:30 PM - Interview with E6 (UM), who shared that E12 (nurse) informed her of the issue with E11 (SLP) not wearing PPE or washing hands while in R197's room. E6 stated she had already notified E2 (DON), who, through the Director of Rehabilitation, will ensure that all Rehabilitation staff will have an in-service regarding contact precautions.</p> <p>Based on the foregoing circumstances, it was determined that the facility failed to meet professional standards in the area of comprehensive transmission-based precautions</p>	F 880			

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F 880	Continued From page 45 to prevent the spread of disease. Findings were reviewed with E1 (NHA), E2 (DON), E27 (Regional VP), E17 (Medical Director) and E18 (Corporate Nurse) on February 18, 2020 during the exit conference beginning at approximately 1:15 PM.	F 880			



DELAWARE HEALTH AND SOCIAL SERVICES

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

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

STATE SURVEY REPORT

NAME OF FACILITY: Harbor Health Care

DATE SURVEY COMPLETED: February 18, 2020

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
<p>3201</p> <p>3201.1.0</p> <p>3201.1.2</p>	<p>The State Report incorporates by reference and also cites the findings specified in the Federal Report.</p> <p>An unannounced annual and complaint survey was conducted at this facility from February 10, 2020 through February 18, 2020. The facility census the first day of the survey was 151. The investigative sample size was 32. During this period an Emergency Preparedness Survey was also conducted by the State of Delaware's Division of Health Care Quality, Office of Long Term Care Residents Protection in accordance with 42 CFR 483.73.</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 18, 2020: F550, F656, F657, F679, F686, F690, F693, F697, F725, F758, F791, F810, F812, and F880.</p>	<p>Harbor Healthcare has received the statement of deficiencies for the annual survey completed on February 18, 2020. The following is a Plan of Correction to address the alleged deficiencies. The center provides the Plan of Correction without admitting to or denying the validity or existence of the alleged deficiencies. The Plan of Correction is prepared and executed solely because it is required by the provision of federal and state law. We request that you consider the Plan of Correction as the center's allegation of substantial compliance as February 10, 2020.</p> <p>Cross Refer to the CMS 2567-L Plan of Correction Submitted for survey completed February 18, 2020: F550, F656, F657, F679, F686, F690, F693, F697, F725, F758, F791, F810, F812, and F880.</p>	<p>May 1, 2020</p>

Provider's Signature

Title

Administrator

Date

3/20/2020