

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

PRINTED: 05/30/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085029	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/21/2019
NAME OF PROVIDER OR SUPPLIER HARRISON SENIOR LIVING OF GEORGETOWN, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 110 W. NORTH STREET GEORGETOWN, DE 19947		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
E 000	Initial Comments An unannounced annual and complaint survey was conducted at this facility from May 13, 2019 through May 21, 2019. The facility census the first day of the survey was 131. During this period an Emergency Preparedness Survey was also conducted by the State of Delaware's Division of Health Care Quality Long Term Care Residents Protection in accordance with 42 CFR 483.73. For the Emergency Preparedness survey no deficiencies were cited.	E 000			
F 000	INITIAL COMMENTS An unannounced annual and complaint survey was conducted at this facility from May 13, 2019 through May 21, 2019. The deficiencies contained in this report are based on observation, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 131. The survey sample totaled fifty three (53). Abbreviations/Definitions used in this report are as follows: Acute Respiratory Failure - not enough oxygen passes from the lungs to the body; AD - Activity Director; ADLs - Activities of Daily Living, such as bathing and dressing; 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;	F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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 Supervision - oversight, encouragement or cueing; Total Dependence - full staff performance every time activity performed; ADON - Assistant Director of Nursing; AIMS (Abnormal Involuntary Movement Scale) - test to look for uncontrollable body movements, side effect of antipsychotic medications; Alzheimer's Disease - brain disorder causing loss of memory, thinking and language; Analgesic - pain medication; Anxiety - intense, excessive and persistent worry or fear about everyday situations; Antipsychotic - drug to treat psychosis and other mental/emotional conditions; Aspiration pneumonia - lung infection from inhaling food, fluid or vomit; A/V (arteriovenous) shunt - surgical connection of an artery and vein in the arm for use during dialysis; BID - two times daily; 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 BiPAP - a device providing pressurized air through a mask to support breathing; Bipolar Disorder - mood disorder with periods of sadness and excitement; Bipolar Disorder - mood disorder with periods of sadness and excitement; Blood pressure (BP) - measure of the force of blood against the walls of a blood vessel; Bowel and Bladder Trial - 3 day monitoring of incontinence to assess toileting needs; Bruit - hear a whoosh of blood through the dialysis graft (shunt); Capsules - encapsulation of medication into a shell which can be swallowed easier;	F 000			

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F 000	Continued From page 2 Care Area Summary (CAA) - part of the MDS assessment to identify and plan for problem areas; Cerebral Palsy - condition marked by impaired muscle coordination (spastic paralysis) and/or other disabilities typically caused by damage to the brain before or at birth; CDC - Centers for Disease Control and Prevention; Chronic obstructive pulmonary disease (COPD) - progressive lung disease that makes it hard to breathe; CNA - Certified Nurse's Aide; Cognitive function - mental abilities; Cognitively intact - able to make own decisions; Communicable Disease - disease that is spread from one person to another; Continence - control of bladder and bowel function; Contracture / contracted - joint with fixed resistance to passive stretch of a muscle and cannot straighten; Culture & Sensitivity (C&S) - test to see what bacteria is causing the infection and which antibiotic will kill it; Delirious / Delirium - brief state of excitement and mental confusion; Delusion / delusional - false belief that is thought to be true; Dementia - loss of mental functions such as memory and reasoning that is severe enough to interfere with a person's daily functioning; Depakote Sprinkles Capsule Delayed Release Sprinkle - a medication for seizures and mood disorders; Depression - mood disorder with feelings of sadness; Dermatitis - irritation of the skin; DON - Director of Nursing; DuoNeb Solution - liquid medication that is	F 000		

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F 000	Continued From page 3 inhaled via a mist (nebulizer) which relaxes and opens airways and makes it easier to breathe; Dycem - an anti slip material used to prevent slipping or falling; Dysphagia - difficulty swallowing; Dialysis - cleansing of the blood by artificial means when kidneys have failed; Dialysis communication book - binder with paper for facility and dialysis center to record resident assessment including pre and post treatment weights; e.g. - abbreviation that means "for example;" eMAR - electronic Medication Administration Record; eTAR (electronic Treatment Administration Record) - list of resident treatments that are signed off when completed; etc. - abbreviation for the Latin word et criteria - which means "and so on;" EMR - Electronic Medical Record; ER - Emergency Room; F (Fahrenheit) - measurement of temperature; FMP (Facility Maintenance Program) - scheduled tasks, like walking, to maintain function; Foley - brand of urinary catheter to drain urine from bladder; FSD - Food Service Director; Graft - see A/V shunt; Hallucinations - something that seems real but does not really exist; High Blood Pressure (Hypertension) - blood flows through blood vessels, or arteries, at higher than normal pressures and can cause organ damage, leading cause of stroke; HS - hour of sleep; i.e. - abbreviation used to give more information about something that was just mentioned; Incontinence - loss of control of bladder and bowel function; Always incontinent - no episodes of continence;	F 000		

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F 000	Continued From page 4 Frequently incontinent - 7 or more episodes of incontinence, but at least one episode of continent voiding during a 7 day period; Occasionally incontinent - less than 7 episodes of incontinence; Intravenous (IV) - administration of medications/fluids through a tube directly into a vein; Laxative - medication to promote a bowel movement; LPN - Licensed Practical Nurse; LTC - long term care; MD - Medical Doctor; MDS (Minimum Data Set) - standardized assessment used in nursing homes; Medication Regimen Review (MRR) - monthly review of resident medications, laboratory tests etc. by a pharmacist to see if anything unusual exist; Metoprolol - a medication for high blood pressure; Mid Level Provider - nurse practitioner or physician assistant; mL (milliliters) - measurement of liquid 5 ml = 1 teaspoon; mg (milligrams) - measurement of weight; Moderate Cognitive Impairment - decisions poor, cues / supervision required; MOM (Milk of Magnesia) - liquid medication to promote a bowel movement; Nebulizer - machine that turns liquid medication into a mist which is inhaled directly into lungs; Neuralgia - pain caused by nerve irritation; Neurological checks / assessments - series of questions and physical tests to see if the nervous system is impaired; NHA - Nursing Home Administrator; Nocturnal - done, occurring, or active at night; NP - Nurse Practitioner; Orthotic - externally applied device to change the structure and function of the muscle / bones;	F 000		

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F 000	Continued From page 5 Overactive bladder - sudden involuntary contraction of the bladder causing urinary urgency, an immediate unstoppable need to urinate; a form of urinary incontinence; Oxybutynin Chloride - a medication for bladder incontinence; Oxygen - odorless gas in the air needed to maintain life; can be given by nasal cannula and mask. Pain Scale - rating pain severity on a 0 to 10 scale with 0 meaning no pain and 10 meaning the worst pain; Paranoia - extreme fear of perceived danger; Parkinsons disease - brain disorder affecting movement leading to shaking/tremors and difficulty walking; PASARR (Pre-Admission Screening and Annual Resident Review) - evaluation performed for determination of mental illness and recommendations; PAS Unit (Preadmission Screening Unit) - Screening unit to identify persons with possible mental illness or mental retardation or related conditions who are applying to, or residing in, nursing facilities; POS (Physician Order Sheet) - monthly list of current physician orders; + - positive; Post - after; Pre - before; lbs (pounds) - abbreviation for weight; % - percentage; Peripherally Inserted Central Catheter (PICC) - special catheter in the vein that can be used for a longer period of time; PRN - when necessary; Psychoactive medication - drug used to change brain function to change mood, perception or consciousness; Psychologist - provider specializing in mental	F 000		

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F 000	Continued From page 6 disorders; Psychosis - loss of contact/touch with reality; Psychosocial - mental and emotional health; Psychotropic (medication) - medication capable of affecting the mind, emotions, behavior; PT - Physical Therapy / Therapist; PTA - Physical Therapy Assistant; QA - Quality Assurance Quadriplegic - inability to use arms and legs due to paralysis/weakness; Range of Motion (ROM) - extent to which a joint can be moved safely; RN - Registered Nurse; RNAC - Registered Nurse Assessment Coordinator; Spastic - tightening of muscles causing awkward movements; Systolic blood pressure - top number of the BP reading; Tablet - pill form of a medicine; Thrill - feel blood flow through the dialysis graft (shunt); Transmission-based precautions (isolation precautions) - wearing disposable gown and gloves to help the spread of germs from one person to another; UM - Unit Manager; UTI - urinary tract infection.	F 000			
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at	F 565			

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F 565	<p>Continued From page 7</p> <p>the respective group's invitation.</p> <p>(iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings.</p> <p>(iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility.</p> <p>(A) The facility must be able to demonstrate their response and rationale for such response.</p> <p>(B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group.</p> <p>§483.10(f)(6) The resident has a right to participate in family groups.</p> <p>§483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and review of resident council meeting minutes, it was determined that the facility failed to have evidence of promptly acting upon the grievances and recommendations from the group. In addition, the facility failed to demonstrate their response and rationale for such responses. Findings include:</p> <p>The facility's policy titled, Resident Council, with a revision date of March 2019 documented: "1. The purpose of the Resident Council is to provide a forum for:...</p> <p>b. Discussion of</p>	F 565		

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F 565	<p>Continued From page 8 concerns;..."</p> <p>"7. The facility department manager related to any issues will be responsible to address the item(s) of concern."</p> <p>"8. Minutes include names of the council members and any guests present; issues discussed; recommendations from the council and follow-up on prior issues."</p> <p>"9. Issues documented on the council minutes, not resolved during the meeting, are referred to the department manager for timely resolution and follow-up. Issues documented on council response forms may be re-referred to the Quality Assurance Committee, if applicable (i.e. the issues is a serious nature."</p> <p>February 2019 through April 2019 - A review of the Resident Council Meeting Minutes revealed lack of evidence of:</p> <ul style="list-style-type: none"> - addressing the concern and/or; - follow up information on the status of their concerns. <p>5/15/19 beginning at approximately 10:30 AM - A meeting was held with ten (10) residents (A1 through A10), who voiced lack of follow-up to the concerns raised during the above Resident Council Meetings from February 2019 through April 2019. Common concerns were regarding meals and missing items.</p> <p>5/17/19 at approximately 1:30 PM - The surveyor was provided information by E8 (AD), as facility's alleged evidence of a follow-up to the concerns on a monthly basis. There was lack of evidence, that the concerns were promptly addressed and followed-up by the facility.</p> <p>5/21/19 beginning at approximately 9:00 AM - Above findings reviewed and confirmed with E 1</p>	F 565		

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F 565	Continued From page 9 (NHA) and E8 (AD). E1 verbalized a new tracking tool has been developed and will be utilized to ensure each concern was promptly addressed and follow-up. Findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) on 5/21/19 during the exit conference beginning at 1:55 PM.	F 565		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or	F 622		

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F 622	<p>Continued From page 10</p> <p>(F) The facility ceases to operate.</p> <p>(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.</p> <p>§483.15(c)(2) Documentation.</p> <p>When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.</p> <p>(i) Documentation in the resident's medical record must include:</p> <p>(A) The basis for the transfer per paragraph (c)(1)(i) of this section.</p> <p>(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).</p> <p>(ii) The documentation required by paragraph (c)(2)(i) of this section must be made by-</p> <p>(A) The resident's physician when transfer or discharge is necessary under paragraph (c)(1)(A) or (B) of this section; and</p> <p>(B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section.</p> <p>(iii) Information provided to the receiving provider must include a minimum of the following:</p>	F 622		

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F 622	<p>Continued From page 11</p> <p>(A) Contact information of the practitioner responsible for the care of the resident.</p> <p>(B) Resident representative information including contact information</p> <p>(C) Advance Directive information</p> <p>(D) All special instructions or precautions for ongoing care, as appropriate.</p> <p>(E) Comprehensive care plan goals;</p> <p>(F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, review of other facility documentation and interview, it was determined that the facility failed to fully complete the Nursing Home Transfer and Discharge Notices for two (R51 and R98) out of four sampled residents reviewed for hospitalizations. The facility failed to fully complete the required documentation with regard to the basis (reason) of the resident transfer. Findings include:</p> <p>Review of "Resident Rights" in facility admission packet reveals ".... (5) Contents of Notice. The written notice specified in paragraph (b)(3) of this section must include the following: (i) the reason for transfer of discharge."</p> <p>1. Review of R51's clinical records revealed the following:</p> <p>3/1/19 - R51 transferred to the hospital.</p> <p>5/19/19 - Review of Nursing Home Transfer and Discharge Notice revealed that the reason for the transfer was not marked.</p>	F 622		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085029	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/21/2019
NAME OF PROVIDER OR SUPPLIER HARRISON SENIOR LIVING OF GEORGETOWN, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 110 W. NORTH STREET GEORGETOWN, DE 19947		
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F 622	Continued From page 12 2. Review of R98's clinical records revealed the following: 3/6/19 - R98 transferred to the hospital. 5/19/19 - Review of Nursing Home Transfer and Discharge Notice revealed that the reason for the transfer was not marked. 5/20/19 - approximately 12:18 PM - Interview with E2 (DON) and E13 (Admissions) confirmed that reason for R91's transfer to the hospital should have been checked. It was confirmed that the reason for transfer was stated in computer progress notes, but not on the required form. 5/20/19 2:14 PM - Interview with E2 (DON), who stated that the facility's policy is being revised. An earlier mock survey identified concerns with the completion of the transfer/discharge form. Once the form and policy were completed, staff will be educated as to the updates. Findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) on 5/21/19 during the exit conference beginning at 1:55 PM.	F 622		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or	F 623		

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F 623	<p>Continued From page 13</p> <p>discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and</p> <p>(iii) Include in the notice the items described in paragraph (c)(5) of this section.</p> <p>§483.15(c)(4) Timing of the notice.</p> <p>(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.</p> <p>(ii) Notice must be made as soon as practicable before transfer or discharge when-</p> <p>(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;</p> <p>(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;</p> <p>(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;</p> <p>(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or</p> <p>(E) A resident has not resided in the facility for 30 days.</p> <p>§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:</p> <p>(i) The reason for transfer or discharge;</p> <p>(ii) The effective date of transfer or discharge;</p> <p>(iii) The location to which the resident is transferred or discharged;</p> <p>(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how</p>	F 623		

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F 623	Continued From page 14 to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).	F 623			

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F 623	Continued From page 15 This REQUIREMENT is not met as evidenced by: Based on record review it was determined that the facility failed to provide notification of transfer in a timely fashion for one (R106) out of four residents sampled for hospitalization. Findings include: Review of R106's clinical record revealed: 5/8/19 - R106 sent to the hospital for fever and difficulty breathing. 5/21/19 (9:25 AM) - E13 (Admissions) provided a copy of the transfer notice to the surveyor. Review of the transfer notice revealed that telephone notification to R106's responsible person was completed 8 days after transfer on 5/16/19 by E1 (NHA). Notice was not made as soon as practicable before for the immediate transfer for R106's urgent medical needs. Findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) on 5/21/19 during the exit conference beginning at 1:55 PM.	F 623			
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if	F 625			

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F 625	<p>Continued From page 16</p> <p>any, during which the resident is permitted to return and resume residence in the nursing facility;</p> <p>(ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;</p> <p>(iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and</p> <p>(iv) The information specified in paragraph (e)(1) of this section.</p> <p>§483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview it was determined that the facility failed to provide bed hold notice for one (R106) out of four residents sampled for hospitalization. Findings include:</p> <p>Review of R106's clinical record revealed:</p> <p>5/8/19 - R106 sent to the hospital for fever and difficulty breathing.</p> <p>5/20 (4:00 PM) - The surveyor requested bed hold and transfer notices for for R106's recent hospitalization from E13 (Admissions).</p> <p>5/21/19 (9:25 AM) - E13 (Admissions) provided a copy of the transfer notice to the surveyor but lacked the bed hold notice which was confirmed at that time.</p>	F 625		

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F 625 F 644 SS=D	Continued From page 17 Findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) on 5/21/19 during the exit conference beginning at 1:55 PM. Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1) Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to notify the appropriate State Agency, DMMA PAS Unit (Division of Medicaid and Medical Assistance Pre-Admission Screening Unit), of the need to complete a Resident Review, after a change in status, related to a mental illness for two (R30 and R98) out two sampled residents reviewed for PASRR. In addition, the facility failed to have a policy/procedure and/or an effective system in place to identify residents needing a PASRR (Pre-Admission Screening Resident Review). Findings include:	F 625 F 644		

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F 644	<p>Continued From page 18</p> <p>Federal Regulations require completion of the PASRR to screen persons for possible mental illness, mental retardation or related conditions who are applying to or residing in a Medicaid certified nursing facility. After a change in status related to a mental illness, the facility is responsible for notifying the appropriate State agency of need for a PASRR resident review to ensure needed services are provided.</p> <p>1. The following was reviewed in R30's clinical record:</p> <p>4/13/15 - R30 was admitted to the facility.</p> <p>8/31/18 - A psychologist consultation note documented a new mental illness diagnosis of major depression.</p> <p>There was lack of evidence of a PASRR when R30 was newly diagnosed with mental illness on 8/31/18.</p> <p>5/14/19 at approximately 11:38 AM - An interview with E5 (SSD) revealed, when a new mental illness diagnosis, such as major depression was determined for a resident, the facility would initiate a referral to DMMA PAS Unit for a Resident Review. E5 confirmed the facility failed to initiate a referral for a PASRR Resident Review.</p> <p>2. The following was reviewed in R98's clinical record:</p> <p>5/1/18 - R98 was admitted to the facility.</p> <p>3/12/19 - A mental health nurse practitioner consultation note documented a new mental</p>	F 644		

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F 644	Continued From page 19 illness diagnoses of delusional disorder and bi-polar disorder. There was lack of evidence of a PASRR when R98 was newly diagnosed with mental illness on 3/12/19. 5/14/19 at approximately 11:38 AM - An interview with E5 (SSD) confirmed that the facility failed to initiate a referral for a PASRR Resident Review. Findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) on 5/21/19 during the exit conference beginning at 1:55 PM.	F 644			
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR	F 656			

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F 656	<p>Continued From page 20</p> <p>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 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 the facility failed to ensure comprehensive care plans were individualized for two (R106 and R329) out of 30 sampled residents. Findings include:</p> <p>Cross Refer F690</p> <p>1. Review of R106's clinical record revealed:</p> <p>4/9/19 - Hand off communication form, completed by the facility nurse when getting report from the hospital nurse, included that R106 had a urinary catheter inserted on 4/7/19 due to urine retention.</p> <p>Review of the care plan revealed that R106 did not have a care plan developed for urine retention.</p> <p>Cross Refer F698</p> <p>2. Review of R329's clinical record revealed:</p>	F 656			

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F 656	Continued From page 21 5/5/19 (1:34 AM) - Nursing progress note documented R329 was admitted with a "dialysis shunt present to the rt (right) side of upper chest." This was a dialysis catheter and not a shunt. 5/5/19 (6:30 AM) - Nursing note documented that R329's (brand of catheter) was "intact right upper chest wall." Care plan 5/3/19 - Care plan for nutritional problems related to therapeutic diet, elevated BMI (body mass index - overweight). There was nothing in the care plan about nutritional needs related to kidney failure and dialysis. 5/3/19 - Care plan for dialysis included the intervention "do not take BP in arm with graft (shunt)." R319 did not have a graft/shunt but had a catheter. 5/20/19 (around 9:30 AM) - During an interview E38 (RNAC) confirmed the care plan included that R329 had a shunt. Findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) on 5/21/19 during the exit conference beginning at 1:55 PM.	F 656			
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the	F 657			

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F 657	Continued From page 22 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 and interview it was determined that the facility failed, for two (R76 and R329) out of five residents investigated for medication review, to revise the care plan to reflect current interventions. Findings include: 1. Review of R76's clinical record revealed: 8/7/18 - Care plan initiated for risk for bladder incontinence related to neurogenic bladder (inability to hold or empty urine)...intermittent catheterization. 4/14/19 - Review of urinary consultation outside the facility revealed R76 should "continue TID (three times a day) self cath (insert catheter to drain bladder, then remove catheter) unless deconditioned then staff to do in bed." 4/30/19 - Physicians' order for an indwelling	F 657			

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F 657	Continued From page 23 urinary catheter. The care plan was not revised to reflect the indwelling catheter. 2. Review of R332's clinical record revealed: 4/29/19 - Care plan for fall risk initiated. 5/8/19 - Review of CNA tasks found "clip alarm: bed/chair" was added for CNAs to document alarm use and function. 5/17/19 (11:15 AM) - An interview with R38 (RNAC) confirmed the care plan lacked the clip alarm. R38 revealed the facility had two sets of care plan selections in the computer and was transitioning from one to the other. The "alarm was not in the directory. I just added it." Findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) on 5/21/19 during the exit conference beginning at 1:55 PM.	F 657		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to follow physicians orders for three (R76, R329 and	F 684		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085029	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/21/2019
NAME OF PROVIDER OR SUPPLIER HARRISON SENIOR LIVING OF GEORGETOWN, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 110 W. NORTH STREET GEORGETOWN, DE 19947		
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F 684	<p>Continued From page 24</p> <p>R332) out of five residents investigated for medication review. For R329 a blood pressure medication was held when the parameters were incorrectly entered in the computer (ordered). For R76 and R332 the bowel protocol was not implemented as prescribed. Findings include:</p> <p>Cross Refer F756, Example 4</p> <p>1. Review of R329's clinical record revealed:</p> <p>5/2/19 - Telephone order entered in the computer for two blood pressure medications (amlodipine and metoprolol). The parameter for each medication included to hold the medication for systolic blood pressure greater than 110 or heart rate greater than 55. The parameters should have been to hold the blood pressure medication if LESS than the parameters since blood pressure medication reduces the blood pressure.</p> <p>5/3/19 - Review of the Admission Drug Regimen Review Reporting Form revealed the incorrect parameter was identified only for the metoprolol but not the amlodipine.</p> <p>Review of an Order Summary Report identified the wording of the parameter was corrected to include "LESS" than:</p> <ul style="list-style-type: none"> - 5/3/19: metoprolol. - 5/10/19: amlodipine. <p>May, 2019 - Review of the eMAR and nursing progress notes revealed R329's amlodipine was held twice when the BP reading were high, indicating the medication was needed.</p> <ul style="list-style-type: none"> - 5/5/19: BP 213/80. - 5/8/19: BP 171/70. <p>5/20/19 (around 10:50 AM) - An interview with E38 (RNAC) confirmed that R329 did not receive</p>	F 684			

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F 684	<p>Continued From page 25</p> <p>two doses of amlodipine when the resident's BP was high.</p> <p>Bowel Protocol 1/25/19 - Review of facility policy entitled Bowel Protocol revealed "Prior to administering laxative, address with CNAs and / or determine if bowel movement has occurred. The laxatives will be documented on the MAR. The staff nurse will make sure, at the completion of their shift, that all residents requiring laxatives have been provided a laxative. 9 shifts without a bowel movement - MOM - Milk of Magnesia (or ordered alternative) will be administered and documented. 10 shifts without BM - suppository (or ordered alternative)...11 shifts without BM - enema (or ordered alternative)...If at any stage a resident refuses an intervention proceed to the next step and document in nurses notes. Notify physician of any refusal."</p> <p>5/17/19 (8:35 AM) - An interview with E2 (DON) revealed that the bowel protocol should start at the end of the 9th shift.</p> <p>2. Review of R76's clinical record revealed:</p> <p>1/15/19 - Care plan for constipation had the goal to have a normal BM at least every 3 days. Interventions included to "Follow bowel protocol for bowel management. Record BM pattern each day."</p> <p>4/25/19 - Physicians' orders after a hospitalization included bowel protocol.</p> <p>April - May 2019 - Review of CNA documentation for BMs, nursing progress notes and eMAR for bowel protocol implementation found: - 5/12/19: R76 had a medium BM on day and</p>	F 684			

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F 684	Continued From page 26 evening shifts. - 5/15/19: There was no evidence that MOM was administered or refused after the evening (9th) shift. - 5/16/19: R76 given suppository on day (11th) shift which produced a large BM. 5/20/19 (1:15 PM) - Interview with E2 (DON) to review the aforementioned finding. E2 indicated he/she would "check on bowel list" for an explanation. E2 (DON) provided no explanation by the exit conference on 5/21/19 at 1:55 PM. 3. Review of R332's clinical record revealed: 4/29/19 - Admission to the facility after hospitalization with orders including bowel protocol. May 2019 - Review of CNA documentation for BMs, nursing progress notes and eMAR for bowel protocol implementation found: - 5/9/19: R332 had a large BM on evening shift. - 5/12/19: MOM administered at 6:40 PM and 10:22 PM (on the 9th shift). There was no evidence as to why two doses of the medication were given within 4 hours. 5/17/19 (10:37 AM) - During an interview with E2 (DON) to review that R332 received two doses of MOM within 4 hours on the same shift, E2 offered no explanation. Findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) on 5/21/19 during the exit conference beginning at 1:55 PM.	F 684			
F 688	Increase/Prevent Decrease in ROM/Mobility	F 688			

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F 688 SS=D	<p>Continued From page 27 CFR(s): 483.25(c)(1)-(3)</p> <p>§483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and</p> <p>§483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.</p> <p>§483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that for one (R116) out of one sampled residents reviewed for range of motion, the facility failed to follow a physician's order for splint application to R116's bilateral wrists. Findings include:</p> <p>The Facility Policy (last revised 1/25/19) entitled Resident Mobility and Range of Motion Policy included: -Residents with limited range of motion will receive treatment and services to increase and/or prevent a further decrease in range of motion.</p> <p>6/7/16 - R116 was admitted to the facility with a diagnosis of Spastic Quadriplegic Cerebral Palsy.</p> <p>6/14/16 - R116's Orthotic Care Plan included:</p>	F 688		

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F 688	<p>Continued From page 28</p> <p>Bilateral hand splints - on 4 hours / off 4 hours. On at 4:00 AM; off at 8:00 AM; on at 12:00 PM; off at 4:00 PM; on at 8:00 PM; off at 12:00 AM. Skin checks every 2 hours while in place. Monitor for pain, pressure, swelling, redness, etc. and notify Nursing / Physician. Therapy screens as indicated with annual range of motion measurements.</p> <p>4/15/19 - R116's Significant Change MDS included: R116 was severely cognitively impaired and dependent on staff for all of his care needs.</p> <p>5/1/19 - R116's Annual Range of Motion Assessment documented that R 11's left wrist was moderately contracted (31-50 degrees) and right wrist was minimally contracted (5-30 degrees). A physician's order for splints included: Bilateral hand orthotics during 8 AM care. Four hours on, 4 hours off around the clock. Any signs or symptoms of skin irritation, remove and notify therapy.</p> <p>5/14/19 10:34 AM - During an interview with E16 (CNA), it was revealed that R116's splint schedule was in the CNA documentation.</p> <p>R116's splint order and care plan indicated the splints were to be on from 12:00 PM to 4:00 PM.</p> <p>The following observations were made of R116 without bilateral wrist splints on: 5/15/19 1:03 PM; 5/15/19 1:19 PM; 5/15/19 1:38 PM; 5/15/19 3:01 PM; 5/15/19 3:15 PM; 5/20/19 12:22 PM; and 5/20/19 2:50 PM.</p> <p>5/15/19 3:30 PM - During an interview with E17 (PTA), it was confirmed that R116's bilateral wrist splints were not in place.</p>	F 688		

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F 688	Continued From page 29 5/15/19 3:47 PM - During an interview with E18 (CNA), it was revealed that the splint application schedule could be found in the CNA computer documentation. E18 researched the CNA's tasks in the computer documentation for splint application and reported that R116's splints were to be four hours on and four hours off. E18 stated that bilateral wrist splints should have been applied at 12:00 PM and in place until 4:00 PM. E18 accompanied the surveyor to R116's room, and confirmed that R116's bilateral wrist splints were not in place. Findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) on 5/21/19 during the exit conference beginning at 1:55 PM.	F 688		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that for one (R8) out of one sampled residents reviewed for falls/accidents, the facility failed to assess fall risk related to toileting and develop a plan to provide supervision to prevent further falls. Findings include: The facility policy (last revised 1/25/19) entitled Falls-Clinical Protocol Policy included: - The staff will document risk factors for falling in	F 689		

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F 689	<p>Continued From page 30</p> <p>the resident's record and discuss the resident's fall risk.</p> <ul style="list-style-type: none"> - For an individual who has fallen, staff will attempt to define possible root causes within 24 hours of the fall. - The staff and the physician will continue to collect and evaluate information until either the root cause of the falling is identified, or it is determined that the root cause cannot be found or that finding a root cause would not change the outcome. - The staff will monitor and document each resident's response to interventions intended to reduce falling or the risk of falling. <p>Cross Refer F690 The following was reviewed in R8's clinical record:</p> <p>2/11/17 - R8 was admitted to the facility with a diagnosis of Alzheimer's Dementia.</p> <p>R8's care plan included the approaches: 10/16/18 - Establish voiding patterns. 1/11/19 - (R8) frequently self-transfers. 4/19/19 - Bowel and bladder trial.</p> <p>2/4/19 3:00 AM - A progress note documented that staff heard resident's rolling walker hit the floor. E29 (LPN) responded to room and noted R8 had fallen out of bed to door side of the floor at 3:00 AM. R8 stated he/she slid off (of) the bed. R8 was attempting to go to the bathroom without assist. The facility initiated dycem to the mattress, Physical Therapy screen, bowel and bladder trial, and neurological checks.</p> <p>2/5/19 - A Significant Change of Status MDS documented for R8: moderately cognitively impaired; extensive assist of one for bed mobility</p>	F 689		

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F 689	<p>Continued From page 31 and limited assist for transfers and ambulation; occasionally incontinent of urine and frequently incontinent of bowel.</p> <p>2/7/19 - A 3 Day Incontinence Monitoring Record was put in place, but was incomplete and lacked evidence of toileting from 3:00 PM to 10:00 PM.</p> <p>2/8/19 2:50 AM - A progress note documented R 8 fell again attempting to go the bathroom.</p> <p>2/8/19 - Another 3 Day Incontinence Monitoring Record lacked evidence of toileting from 12:00 PM to 10:00 PM. Written over 12:00 PM to 2:00 PM was the word Kent. From 3:00 PM to 10:00 PM there was line through the documentation squares.</p> <p>There was no evidence that the facility established an individualized toileting plan to prevent further falls.</p> <p>2/22/19 - A 3 Day Incontinence Monitoring Record was initiated and lacked evidence of urinary incontinence monitoring from 6:00 AM to 10:00 PM.</p> <p>3/9/19 11:30 PM - A progress note documented that R8 fell again attempting to go to the bathroom.</p> <p>4/18/19 2:07 AM - A progress note revealed R8 sustained another fall attempting to go to the bathroom.</p> <p>May 2019 - The facility developed a toileting program to toilet R8 at 12:00 AM; 4:00 AM; 8:00 AM; 11:00 AM; 2:00 PM; 4:00 PM; 7:00 PM; and 10:00 PM without evidence of a completed toileting assessment.</p>	F 689			

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F 689	Continued From page 32 5/9/19 - R8's fall risk score was 19 which signified that R8 was a high risk for falling. The facility failed to complete R8's 3 day voiding trial and implement an individualized toileting plan to maintain continence and prevent recurrent falls while attempting to go to the bathroom. Findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) on 5/21/19 during the exit conference beginning at 1:55 PM.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §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. §483.25(e)(2) For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (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; (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 (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore	F 690		

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F 690	Continued From page 33 continence to the extent possible. §483.25(e)(3) For a resident with fecal 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. This REQUIREMENT is not met as evidenced by: Based on record review, interview and review of other facility documentation it was determined that, for two (R106 and R8) out of three residents investigated for Catheter / UTI, the facility failed to provide care and services to maintain bladder function to the extent possible. For R106, the facility failed to monitor for excessive post void residual (PVR) after removal of an indwelling urinary catheter (catheter held in the bladder with a balloon to drain urine) that was inserted for urinary retention (inability to fully empty bladder). For (R8), the facility failed to fully complete a three day Incontinence Monitoring Record to evaluate R8's toileting and failed to develop an individualized toileting plan to maintain bladder continence. Findings include: 1. August 2014 - National Institute of Diabetes and Digestive and Kidney Diseases, a division of National Institutes of Health, information on bladder infections in adults identified "symptoms of chronic urinary retention: urinary frequency (urination eight or more times a day); trouble beginning a urine stream; weak or an interrupted urine stream; urgent need to urinate with little success when trying to urinate; feeling the need to urinate after finishing urination; and mild and constant discomfort in the lower abdomen and urinary tract. Some people with chronic urinary	F 690			

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F 690	<p>Continued From page 34</p> <p>retention may not have symptoms that lead them to seek medical care. People who are unaware they have chronic urinary retention may have a higher chance of developing complications....bacteria can grow when urine stays in the bladder too long." Post void residual (PVR - amount of urine remaining in the bladder after urination) is one way to help diagnose urine retention. https://www.niddk.nih.gov/health-information/urol-ogic-diseases/urinary-retention (Accessed 5/22/19).</p> <p>5/15/17 - Nursing Times article entitled Urinary Catheters: removing an indwelling catheter revealed a listing of complications following catheter removal: "Urinary retention (inability to pass urine) with symptoms including: Abdominal discomfort and pain; A palpable bladder; Anuria (no urine output) or passing small and frequent amounts of urine; A weak urine stream; Hesitancy; and Straining, feelings of incomplete emptying and after-dribble. If retention is suspected, it is important to perform a bladder ultrasound and recatheterize the patient if indicated." https://www.nursingtimes.net/clinical-archive/continence/urinary-catheters-6-removing-an-indwelling-urinary-catheter/7017977.article (Accessed 5/22/19).</p> <p>3/25/19 - Review of the facility policy entitled Post Foley Monitoring revealed that "residents will have appropriate monitoring and assessment post foley catheter removal." Policy interpretation and implementation included that "Nurses will assess for voiding (urination) every 2 hours for 6-8 hours after discontinuation. If resident is unable to void after 6-8 hours and/or complains of discomfort or voids less than 250 mL over 2-4</p>	F 690			

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F 690	<p>Continued From page 35</p> <p>hours, nurse will assess and document bladder volume using one of the methods below:</p> <ul style="list-style-type: none"> a. Preferred method: bladderscan b. If bladderscan is unavailable, post void residual with straight catheterization if indicated. <p>Review of R106's clinical record revealed:</p> <p>3/2/19 - R106 was admitted to the facility for rehabilitation after surgery for a broken hip with multiple diagnoses including dementia, chronic lung disease and a stroke.</p> <p>3/8/19 - 5-day Medicare MDS Assessment documented R106 had severe cognitive impairment and was frequently incontinent of bowel and bladder.</p> <p>3/21/19 - R106 was sent to the hospital with difficulty breathing.</p> <p>4/9/19 - Hand off communication form, completed by the facility nurse when getting report from the hospital nurse, included that R106 had a urinary catheter inserted on 4/7/19 due to urine retention. R106 returned to the facility.</p> <p>4/9/19 - Hospital discharge summary revealed that R106, in addition to treatment for aspiration pneumonia, was also treated for a UTI and had a urinary catheter placed for urine retention.</p> <p>4/12/19 - Physicians' orders included to discontinue to urinary catheter on 4/21/19.</p> <p>4/12/19 (7:26 AM and 9:40 AM) - eMAR nursing notes documented that R106's urinary catheter was flushed...20mL output, flushed with 60 mL sterile water. 40mL drained after flush...no leaking no blockage noted."</p>	F 690			

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F 690	Continued From page 36 4/15/19 - Facility document entitled Rehabilitation Skilled Charting indicated that charting would occur daily on the day shift beginning 4/22/19. One of the pre-printed areas marked to be addressed in the daily documentation included "Urinary Retention - Document inability to void - monitor and document PVR (bladderscan)...document bladder assessment, localized abdominal distention, pain / discomfort..." 4/16/19 - The Admission MDS Assessment documented that R106 had a urinary catheter during the assessment period. Review of R106's nursing progress and eMAR notes surrounding urinary catheter removal, revealed: - 4/22/19 (2:30 AM): "Remove foley and start voiding trial ... if unable to void after 8 hours, reinsert (size of catheter) foley ... Resident tolerated (removal of catheter) well. Resident informed if unable to void in 8 hours that catheter would be reinserted. No evidence of understanding received from resident." - 4/22/19 (4:03 AM): "Has not voided yet since foley removed 1.5 hours ago." - 4/22/19 (10:47 AM): "Resident was assisted to the bathroom...was able to void , he/she also had a medium BM at the same time. No complain (sic) of lower abdomen discomfort." - 4/22/19 (9:51 PM): "...no noted retention. Abdomen not distended. Incontinent several times this shift." - 4/23/19 (2:41 PM): "voided without difficulty." - 4/23/19 (8:41 PM): "resident urinated." April - May 2019 - Review of Intake and Output Record revealed no urine measurements, both	F 690			

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F 690	<p>Continued From page 37</p> <p>before and after the catheter was discontinued. It was not clear if R106 urinated less than 250 mL over 2-4 hours as stated in facility policy without any urine measurements.</p> <p>May 2019 - 3-Day Incontinence Monitoring Record conducted May 1-3 revealed that R106 was incontinent of urine 6-8 times each day.</p> <p>There was no evidence in the nursing progress notes that any post void residuals were obtained after catheter removal to determine if R106 was experiencing urine retention.</p> <p>5/8/19 (10:18 PM) - R106 was sent to the hospital with difficulty breathing and was admitted for treatment. R106 was also diagnosed with urosepsis (blood infection from a urinary tract infection).</p> <p>5/21/19 (11:00 AM) - During an interview with E2 (DON) to review the lack of measuring urine output and PVR after removal of a urinary catheter which had been inserted for retention, E2 stated, "We do those here." E2 stated he/she would review R106's record.</p> <p>5/21/19 (approximately 1:30 PM) - An interview with E1 (NHA) revealed that the facility planned on revising the policy for monitoring after urinary catheter removal.</p> <p>Cross Refer F689</p> <p>2. The Facility Policy (last revised 1/25/19) entitled Urinary Continence and Incontinence-Assessment and Management included: - As indicated, and if the individual remains incontinent despite treating transient causes of incontinence, the staff will initiate a toileting plan.</p>	F 690			

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F 690	<p>Continued From page 38</p> <ul style="list-style-type: none"> - Toileting programs will start with a 3 to 5 day toileting assistance trial. - The Staff will document the results of the toileting trial in the resident's medical record. If the resident responds well, the toileting program will be continued. <p>The following was reviewed in R8's clinical record:</p> <p>2/11/17 - R8 was admitted to the facility with a diagnosis of Alzheimer's Dementia.</p> <p>2/5/19 - A Significant Change in Status MDS documented R8 was: moderately cognitively impaired; extensive assist of one for bed mobility and limited assist for transfers and ambulation; and occasionally incontinent of urine and frequently incontinent of bowel.</p> <p>2/4/19 3:00 AM - An incident report documented that R8 fell attempting to go to the bathroom.</p> <p>2/7/19 - A 3 Day Incontinence Monitoring Record was put into place but incomplete and lacked evidence of toileting from 3:00 PM to 10:00 PM.</p> <p>2/8/19 2:50 AM - A progress note documented that R8 fell again attempting to go the bathroom.</p> <p>2/8/19 - A 3 Day Incontinence Monitoring Record was incomplete and lacked evidence of toileting from 12:00 PM to 10:00 PM. Written over 12:00 PM to 2:00 PM was the word Kent (name of long term care unit in the facility). From 3:00 PM to 10:00 PM there was a line through the documentation squares.</p> <p>2/18/19 - Revision of R8's care plan included to establish voiding patterns</p>	F 690			

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F 690	Continued From page 39 2/22/19 - A 3 Day Incontinence Monitoring Record was incomplete and lacked evidence of urinary incontinence monitoring from 6:00 AM to 10:00 PM. 3/9/19 11:30 PM - A progress note documented that R8 fell again attempting to go to the bathroom. 4/18/19 2:07 AM - A progress note documented that R8 sustained another fall attempting to go to the bathroom. 4/19/19 - Revision of R8's fall care plan interventions included bowel and bladder trial. May 2019 - The facility developed a toileting program to toilet R8 at 12:00 AM; 4:00 AM; 8:00 AM; 11:00 AM; 2:00 PM; 4:00 PM; 7:00 PM; and 10:00 PM without evidence of a complete assessment. 5/1/19-5/20/19 - Review of R8's Toileting Program revealed that out of 160 opportunities to be toileted, 28 opportunities lacked evidence of toileting. The facility failed to complete the 3 Day Incontinence Monitoring Record and failed to establish an individualized toileting plan based on a comprehensive assessment. Findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) on 5/21/19 during the exit conference beginning at 1:55 PM.	F 690			
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including	F 695			

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F 695	<p>Continued From page 40</p> <p>tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, and record review it was determined that for two (R116 and R31) out of two sampled residents reviewed for respiratory care, the facility failed to provide oxygen services with safe handling and cleaning of respiratory equipment. Findings include:</p> <p>The Facility Policy (last revised 1/25/19) entitled Suctioning the Upper Airway Suctioning included: -Empty and rinse collection container if necessary or as indicated by facility protocol.</p> <p>The following was reviewed in R116's clinical record:</p> <p>1. 6/7/16 - R116 was admitted to the facility with a diagnosis of Spastic Quadriplegic Cerebral Palsy and Acute Respiratory Failure.</p> <p>4/15/19 - R116's Significant Change MDS included: R116 was severely cognitively impaired and dependent on staff for all of his/her care needs.</p> <p>Physician's orders included: 10/1/18 - BiPAP Oxygen nocturnal every day in evening shift for acute respiratory failure. Apply at bed time and remove in the AM. 10/17/18 - Oxygen at 3 Liters per minute via nasal cannula.</p>	F 695		

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F 695	<p>Continued From page 41</p> <p>11/19/18 - Change water bottle weekly 11-7 and as needed if empty. Date bottle when installed.</p> <p>11/19/18 - Oxygen equipment: weekly on 11-7 for every resident on continuous oxygen. Change oxygen tubing and cannula/mask. Label new tubing with date, time and initials.</p> <p>The following observations were made of R116 in bed with oxygen running at 3 Liters per minute, and oxygen nasal cannula and BiPAP oxygen tubing were not labeled: 5/14/19 10:46 AM; 5/15/19 1:13 PM; 5/16/19 8:48 AM; 5/16/19 10:49 AM; 5/17/19 9:15; and 5/20/19 2:48 PM.</p> <p>5/16/19 10:49 AM - Observation of oxygen humidifier bottle empty, and dated 5/11/19.</p> <p>5/16/19 11:16 AM - In an interview with E19 (LPN) (after becoming aware that R116's oxygen water bottle being empty and tubing not labeled), E19 revealed that R116 was to have his oxygen supplies changed on 11-7 on Friday night. E19 stated that she would "take care of it."</p> <p>5/20/19 2:48 PM - Observation of R116's suction canister not labeled with date and full up to approximately one inch from the top with liquid secretions.</p> <p>5/20/19 2:50 PM - In an interview and observation with E2 (DON), E2 confirmed that the oxygen nasal cannula, the Bipap oxygen tubing, and suction container were not dated. E2 then revealed that E19 (LPN) had labeled the oxygen nasal cannula on the (moleskin) ear guards and it must have worn off. Although the ear guards were previously labeled, the tubing was not. E2 confirmed that the suction container was not labeled and was full, and that the BiPAP oxygen tubing was not labeled.</p>	F 695		
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F 695	Continued From page 42 5/21/19 8:12 AM - In an interview with E1 (NHA) he/she reported that it is the standard of practice, and the expectation, that the oxygen tubing and suction containers be labeled with dates and initials. E1 confirmed that suction canisters should be emptied on a regular basis and not left that full. 2. Review of R31's clinical record and facility policies revealed: The Facility Policy (dated April 2019) entitled Oxygen Administration included that weekly changes of oxygen tubing, humidifiers, masks, and cannulas will be documented on treatment administration record. 4/27/18 -A physician's order for DuoNeb Solution 1 applicator full, inhale orally (via nebulizer) every 3 hours around the clock related to chronic obstructive pulmonary disease. 5/4/18 - A physician's order for nebulizer equipment: If resident is ordered a treatment at least once daily, change tubing and set up weekly on 11-7 shift. Label tubing with date, time and initials. Wipe the outside of machine thoroughly with disinfecting wipe. Inspect the machine for damage. If damaged, remove from service. 5/10/19 - The treatment administration record indicates that a nurse changed R31's nebulizer equipment per above order. 5/16/19 at 4:40 PM - During a random medication pass observation, E16 (LPN) administered DuoNeb to R31. This medication was administered via a nebulizer mask dated 4/5/19 which E16 confirmed and later replaced the	F 695			

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F 695	Continued From page 43 outdated equipment. 5/17/19 at 3:00 PM - During an interview, E2 (DON) confirmed that he/she was aware of the above described use of outdated nebulizer equipment and the physician has been notified. Findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) on 5/21/19 during the exit conference beginning at 1:55 PM.	F 695		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to effectively manage pain for one (R330) out of two residents investigated for pain management. R330 was sent to the hospital emergency department to receive pain medication during the first day in the facility. Findings include: 1/1/16 - Facility policy entitled Emergency Pharmacy Service and Automated Emergency Kits identified that pharmacy service was "available on a 24-hour basis. Emergency / interim needs for medications are met by using the facility's approved emergency medication supply or by special order from the provider pharmacy...The Director of Nursing should determine the content of an automated dispensing system in conjunction with Pharmacy...Controlled substances maybe stored	F 697		

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F 697	<p>Continued From page 44</p> <p>in the automated dispensing machine...Upon receipt of a new medication order, facility staff should obtain the total number of doses necessary to cover the period of time from the administration of the first dose until it is expected to become available from the pharmacy."</p> <p>Review of R330's clinical record revealed:</p> <p>5/3/19 - R330 was admitted to the facility around 4:30 PM for rehabilitation after open heart surgery.</p> <p>5/3/19 - Admission physicians' orders included the following medications for pain management:</p> <ul style="list-style-type: none"> - Tylenol every 6 hours PRN for mild pain. - Lyrica twice a day for nerve pain. - Muscle relaxer at bedtime. - Morphine 15 mg (immediate release opioid) four times a day. - Morphine 30 mg extended-release (long acting) three time a day. - Reason for morphine was "long term (current) use of opiate analgesic." <p>5/4/19 - The care plan for pain related to a broken thigh bone and heart valve replacement included the goal that R330 "will have no interruption in normal activities due to pain." Care plan interventions included: Anticipate needs; Monitor / document probable cause for each pain episode; Monitor / report loss of appetite, weight loss, refusal to eat to nurse; Notify physician if interventions are unsuccessful or if current complaint is a significant change from past experience of pain; and Administer pain medications as ordered (added 5/6/19).</p> <p>May 2019 - Review of the eMAR and nursing notes found that on 5/3/19 R330 received the</p>	F 697			

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F 697	<p>Continued From page 45</p> <p>muscle relaxer at bedtime but no Lyrica or morphine. There was no evidence of the Tylenol administration or why the morphine was not available.</p> <p>5/4/19 (12:22 AM) - eMar nursing note documented doctor "made aware" that the morphine was not available from the pharmacy.</p> <p>5/4/19 (Late entry for 11-7 shift) - R330 sent to the hospital "due to uncontrolled pain. Last pain medication resident received was Tylenol from primary nurse at (10:30 PM)." At 1:35 AM 911 called for "incisional (surgical) pain" rating of "10 out of 10 on the numeric (pain) scale." Ambulance personnel arrived at 1:40 AM and report was given. Report called to the nurse at the hospital.</p> <p>5/4/19 - Physicians' orders for pain management changed the immediate release morphine to another opioid (oxycodone) every 6 hours PRN for pain rating 7-10.</p> <p>5/4/19 (2:51 PM) - Nursing note documented R330 returned from the hospital at 9:15 AM. Pharmacy called for needed pain medications.</p> <p>5/4/19 (2:51 PM) - eMar nursing note revealed Lyrica was administered after delivery from the pharmacy. R330 missed two doses of this twice a day medication for nerve pain.</p> <p>Review of eMAR pain assessment documentation on a 0-10 pain scale: - 5/3/19 routine assessment on night shift: 0 (zero) - 5/4/19 routine assessment on day shift: 9 - 5/4/19 prior to 2 PM morphine: 9 (first dose given at facility)</p>	F 697			

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F 697	<p>Continued From page 46</p> <ul style="list-style-type: none"> - 5/4/19 prior to 10 PM morphine: 8 - 5/5/19 prior to 6 AM morphine: 2 - Routine assessments from 5/4/19 (evening shift) through 5/10/19 (night shift) were all 0 (zero). <p>5/13/19 (4:13 PM) - During a resident interview R330 stated he/she was sent to the emergency department on his/her first day here because the facility did not have R330's pain meds. "If I can get to 5 I'm (I am) good. I'm in pain most of time."</p> <p>5/16/19 (8:30 AM) - During an interview with E1 (NHA) to request the medications available in the facility for emergent use E1 stated the hospital failed to send the paper prescriptions for the morphine and Lyrica. E1 revealed that E2 (DON) spoke with the E20 (Physician / Medical Director) who never heard the page. When the surveyor stated there was no evidence that the physician was called in the record, E1 stated, "They should have written that the doctor was called." E1 explained that (name of pharmacy) was the facility's 24 hour pharmacy. But without a hard script (prescription) for the pain medication, the medications could not be obtained. E1 added that the pain medication was added to the stock and contacted case managers at the hospital to remind them to send the hard script. There was no evidence of mention about not having the paper prescription in record. E1 indicated that the quantity of other pain medications were increased.</p> <p>5/16/19 (4:23 PM) - An interview with E2 (DON) confirmed that E20 (Physician / Medical Director) texted the evening supervisor to change the immediate release medication from morphine to oxycodone, but there were none since the</p>	F 697			

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F 697	<p>Continued From page 47</p> <p>quantity in stock was used by another newly admitted resident. E20 was called multiple times to get the pain medication changed to something the facility had available that night, but E20 did not hear the calls and texts since he/she "slept hard."</p> <p>5/17/19 (10:15 AM) - An interview with E21 (RN) in the presence of E2 (DON) revealed E21 was the nursing supervisor on night shift after R330 was admitted on 5/3/19. E21 also provided a written statement:</p> <ul style="list-style-type: none"> - Hospital did not send paper prescription for the pain medication. - Evening shift supervisor obtained an order for another medication (oxycodone), but it was out of stock. - E21 texted and/or called the physician four times without response. - E21 spoke with the pharmacy who wanted the physician to call them with the orders. - E21 called and/or texted E3 (ADON) three times with no response. - E21 called and/or texted E2 (DON) and spoke with E2, explained the situation and obtained approval to send R330 to the emergency department for treatment of pain. <p>Findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) on 5/21/19 during the exit conference beginning at 1:55 PM.</p>	F 697		
F 698 SS=D	<p>Dialysis</p> <p>CFR(s): 483.25(l)</p> <p>§483.25(l) Dialysis.</p> <p>The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.</p>	F 698		

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F 698	<p>Continued From page 48</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to have an agreement with the dialysis center, failed to communicate with the dialysis center to obtain pre and post weights, and failed to consistently / accurately conduct post dialysis assessments for one (R329) out of one resident investigated for dialysis. Findings include:</p> <p>The facility policy entitled Dialysis Resident Care (last revised 1/25/19) included the following procedure: "Request from the dialysis center that pre and post weights and lab reports be sent back to the facility with the resident. After dialysis treatment: Check dialysis shunt for bleeding, presence / absence of bruit and thrill and selling immediately after resident returns to the facility; Observe resident for neurological changes such as lethargy, weakness, dizziness or confusion; Notify the physician of any post-dialysis complications; Review pre and post treatment weights, which will be sent from the dialysis center; Document in (sic) the condition of the resident in the progress notes and record vital signs and any changes."</p> <p>Review of R329's clinical record revealed:</p> <p>5/3/19 (1:34 AM) - Nursing note revealed that R329 arrived to the facility from the hospital around 1:15 AM. R329 was "alert and oriented...cooperative...dialysis shunt present to the rt (right) side of upper chest, no s/s (signs or symptoms) of infection noted."</p> <p>5/3/19 - The care plan for dialysis included interventions: "do not take BP (blood pressure) in arm with graft (resident has catheter and not a</p>	F 698			

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F 698	<p>Continued From page 49</p> <p>graft). I receive dialysis (Monday, Wednesday, Friday) ...monitor labs and report to doctor PRN. Monitor / document peripheral edema (swelling in legs or arms)... monitor/document change in consciousness...heart/lung sounds, no (blood pressures) left arm. Obtain (vital signs) and weight per protocol."</p> <p>May 2019 - Review of documented weights and nursing notes revealed three weights obtained at the facility: There was no evidence of pre and post treatment weights performed on the following dialysis days: May 3, 6, 8, 10 and 13.</p> <p>5/15/19 (9:50 AM) - An interview with R329 revealed that weights were taken at dialysis before and after treatment. "They (dialysis) wrote it down once and gave me a paper." R329 stated that his/her dialysis book was at home and was not given a paper to take to / from dialysis. R329 looked through her papers at the bedside and located the May 2019 quarterly progress report from the dialysis center that contained lab results. This report did not include any weights. When asked if the facility had a copy of this report, R329 responded, "No."</p> <p>5/15/19 (10:10 AM) - An interview with E22 (RN) revealed he/she "made up a (communication) book this morning." E22 added, "We usually communicate by phone with the dialysis place in (name of town)."</p> <p>5/15/19 (around 12:50 PM) - During an interview with E22 (RN) to inquire about location of weights received from dialysis, E22 stated that R329's weights here were weekly, but started doing them daily today. E22 explained that a communication book was started today.</p>	F 698			

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F 698	<p>Continued From page 50</p> <p>5/15/19 (3:50 PM) - Interview with E2 (DON) confirmed the facility did not have an agreement with the dialysis center where R329 had been receiving dialysis since 5/3/19. E2 presented the surveyor with a letter from the dialysis center indicating "the legal department is working on an agreement at this time."</p> <p>5/15/19 (4:10 PM) - Received and reviewed the facility policy entitled Hemodialysis Access Care (revised 1/25/19) which described the care of the dialysis catheter to include that the "site must be kept clean and dry at all times. Catheter lumens should be capped and clamped when not in use...Do not allow non-dialysis personnel to access the catheter...Never pull or tug on the catheter. Do not use scissors near the catheter." Documentation for residents with a dialysis catheter included the "location of catheter, condition of dressing (interventions if needed), if dialysis was done during shift, any part of report from dialysis nurse post dialysis being given, observations post-dialysis."</p> <p>5/16/19 (9:30 AM) - During an interview with E22 (RN) to review the inconsistency of assessment after from dialysis and the lack of pre and post treatment weights, E22 offered no explanation.</p> <p>May 2019 - Review of nursing notes on dialysis days found inconsistent pre and post assessments:</p> <ul style="list-style-type: none"> - May 3: no note before or after dialysis. - May 6: R329 left at 1130 AM for dialysis. Late entry for 3-11 (written 5/7/19) did not address post dialysis assessment or condition of the dialysis catheter. - May 8: R329 left at 11:38 AM to dialysis. No post dialysis note. - May 10: no note before or after dialysis. 	F 698			

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F 698	Continued From page 51 - May 13: R329 left at 11:30 AM for dialysis. - May 15: No note before dialysis. R329 returned at 5:00 PM, vital signs recorded. No weights, post dialysis assessment or condition of the dialysis catheter. Non-dialysis day nursing notes included inaccurate assessments. These two assessments were not accurate since R329 did not have a AV shunt : - 5/4/19 (11:56 PM): "right "A/V shunt with + Bruitt (sic) and thrill." - 5/9/19 (12:36 AM): "Bruit and thrill +". Findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) on 5/21/19 during the exit conference beginning at 1:55 PM.	F 698			
F 713 SS=D	Physician for Emergency Care Available 24 hrs CFR(s): 483.30(d) §483.30(d) Availability of physicians for emergency care The facility must provide or arrange for the provision of physician services 24 hours a day, in case of emergency. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that, for one (R330) out of two residents investigated for pain management, the facility failed to ensure the provision of physician services at night to address a pain management concern. Findings include: Facility policy entitled Physician Responsibilities (revised 1/25/19 and was in place at the time of the incident) included that Emergency Physician Care "is available to all residents on a 24 hour basis. Should the resident's attending physician be unavailable, the nurse supervisor / charge	F 713			

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F 713	<p>Continued From page 52</p> <p>nurse must first attempt to contact the physicians designated referral physician or practitioner. Should the designated referral physician be unavailable to assist in the emergency, the on-call physician or medical director shall be contacted. A listing of on-call physicians, their phone numbers, call (schedule) is posted at each nurses' station."</p> <p>Cross Refer F697 Review of R330's clinical record revealed:</p> <p>5/3/19 (4:29 PM) - Nursing note documented that R330 was admitted to the facility with orders for several controlled medications for pain.</p> <p>5/4/19 (8:00 AM) - Nursing note documented that R330 was sent to the emergency department of the local hospital for treatment of uncontrolled pain around 1:30 AM.</p> <p>5/16/19 (8:30 AM) - An interview with E1 (NHA) confirmed that E20 (Physician / Medical Director) did not respond when the facility attempted contact the night of R330's admission after the hospital did not send the paper prescription for the pain medications.</p> <p>5/16/19 (4:23 PM) - An interview with E2 (DON) to determine how often and when the facility called E20 (Physician / Medical Director) about R330's pain medication concerns revealed that E2 made a call to E21 (night shift RN supervisor) and was waiting for a response.</p> <p>5/17/19 (10:15 AM) - An interview with R21 (RN Night Supervisor), along with E21's written statement provided after the interview, confirmed that E20 (Physician / Medical Director) texted E7 (RN Evening Supervisor) with an order to change</p>	F 713			

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F 713	Continued From page 53 a pain medication to one usually available in the medication dispensing machine. When it was determined that pain medication was out of stock, E21 texted E20 at 11:12 PM, then called and left a voice mail at 11:14 PM. After E21 spoke with the pharmacy to determine a time frame for pain medication delivery, E21 called E20 again at 11:34 PM and 12:34 AM with no response. E21 texted / called E3 (ADON) three times between 12:32 AM and 1:00 AM without response for approval to send R330 to the hospital for treatment. E21 then texted E2 (DON) at 1:02 AM, then called back at 1:19 AM at which time E21 received approval to send R330 to the hospital for pain management. 5/17/19 (around 10:30 AM) - An interview with E2 (DON) revealed that E23 (NP) was on vacation and E24 (NP) "does not take call on Friday nights." E20 (Physician / Medical Director) was apologetic and contacted the facility when he/she awoke around 8:00 AM the next morning. "We are usually able to reach (E20), usually by text." Findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) on 5/21/19 during the exit conference beginning at 1:55 PM.	F 713			
F 744 SS=D	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview it was determined that the facility failed to engage one (R332) out of five residents	F 744			

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F 744	<p>Continued From page 54</p> <p>investigated for dementia care to attain psychosocial well-being. Findings include:</p> <p>Review of R332's clinical record revealed:</p> <p>4/29/19 - Admission to the Rehab (rehabilitation) unit after hospitalization.</p> <p>4/29/19 - Care plan for impaired cognitive function included interventions: "Administer medications for dementia as ordered; Communicate with me / my family / caregivers regarding my capabilities and needs; Discuss concerns about confusion, disease process, NH (nursing home) placement with me / my family / caregivers."</p> <p>5/1/19 - Care plan for adjustment issues related to admission included the goal "I will show evidence of adjustment to nursing home by eating meals in dining room, attending activities daily." The intervention was to "encourage participation in conversation with staff and other residents daily."</p> <p>5/1/19 - Care plan for behavior problem related to disrobing, attempting to self transfer, becoming aggressive and refusing medications and meals included the goal of having less than 5 episodes a week for each of the behaviors. Interventions included: Anticipate and meet the resident's needs; Assist with behavioral symptoms PRN with the following: redirect...activities of interest, supervised area, one on one attention, calm approach, ask my needs. The activities of interest were not specified.</p> <p>5/15/19 (9:05 AM- 12:10 PM)- An observation of R332 seated at a table in the center of the Rehab unit. E32 (Rehabilitation) approached R332 and</p>	F 744			

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F 744	<p>Continued From page 55</p> <p>asked if he/she would "like to come to rehab for therapy?" When R332 refused, E32 left and returned to the rehabilitation department. R332 then played with the arm tray cushion on the wheelchair and removed it. E33 (CNA) put the cushion back in position after asking R332 if he/she wanted to keep it. R332 attempted to propel in wheelchair but the arm rest interfered with the wheel motion. Once R332 attempted to stand unassisted and an unknown staff member yelled from across the room to "sit down." It was not until around 11:00 AM that E34 (CNA) moved R332 to where E34 was documenting. R332 was not offered any other activity or stimulation as E34 returned to completing documentation.</p> <p>5/16/19 (9:15 AM) - An observation of R332 seated at the table in the central area on the Rehab unit. E32 (Rehabilitation) encouraged R332 (instead of asking a yes / no question) to go with E32 to therapy. R332 accompanied E32 to the rehabilitation department for therapy.</p> <p>5/16/19 (approximately 10:00 AM - 10:45 AM) - E32 returned R332 to the table in the center of the Rehab unit. There was a magazine on the table, but R332 was not encouraged to look at it. R332 sat at the table and watched staff walk back and forth through the unit.</p> <p>5/17/19 (9:30 AM) - Observed E36 (Speech Therapist) returning R332 to the rehabilitation unit after therapy and set the resident to the table in the middle of the unit. E36 positioned the activity log form in front of R332 on the table with "This day in history" facing up. Resident appeared to be reading the paper. At 9:50 AM R332 propelled toward a table containing jigsaw puzzles, books and word find puzzles. The surveyor asked R332 if he/she liked to do word find puzzles (while</p>	F 744		

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F 744	<p>Continued From page 56 showing a page in the word find puzzle book). R332 stated "I know how to do that." The surveyor assisted R332 to position the wheelchair at the table and provided the open puzzle book and a pencil. R332 locked the wheelchair at the table and started to look for words in the book.</p> <p>5/17/19 (9:55 AM) - An interview with E22 (RN, UM) revealed that R332 used to attend activities but as he/she got more confused, R332 would try to stand up so R332 was not sent to activities off the unit.</p> <p>5/17/19 (10:45 AM) - An interview with E2 (DON) revealed R332 did much better when his/her spouse was here as a resident. R332 declined after the spouse was discharged.</p> <p>5/17/19 (11:10 AM) - During an interview with E8 (Activities Director) to determine the types of activities conducted or residents with severe dementia, E8 stated, "Some residents go to Kent (long term care unit) or Sussex (dementia unit) for activities." After providing a copy of R332's activity assessment to the surveyor, E8 said, "In rehab, we go around weekly with the cart" (contains independent activities). E8 added that "the dog was just here and (R332) said no." Review of R332's activity assessment showed that R332 "hates dogs." It was not clear why R332 was asked about a dog visit when the resident "hates dogs." When the surveyor pointed out on the assessment sheet that R332 liked to play solitaire, E8 said that there were "cards in the drawer" of the desk / table with puzzles. R332 had severe cognitive impairment and would probably not remember the information about card placement if he/she had been previously told.</p>	F 744			

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F 744	Continued From page 57 Findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) on 5/21/19 during the exit conference beginning at 1:55 PM.	F 744			
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in	F 756			

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F 756	Continued From page 58 the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on facility policy review and interview it was determined that the facility failed to ensure the policy for medication regimen review included time frames for each step of the process. The facility failed to ensure accuracy of the medication regimen reviews for two (R59 and R76) out of five residents investigated for medication review and one (R329) out of three newly admitted residents reviewed. Also, for R76, the pharmacist failed to identify an inaccurate diagnosis for a psychotropic medication. Findings include: 1. Review of pharmacy policy entitled Medication Regimen Review (Monthly Report) (last revised 1/31/17) revealed "Notification made is dependent on severity or irregularity and is determined through consultation between consultant pharmacist and the director of nursing. If no irregularities are found, consultant pharmacist also documents this in the resident's active record and signs and dated such documentation...Recommendations are acted upon and documented by the facility staff and / or the prescriber. Physician accepts and acts upon suggestion or rejects and provides an explanation for disagreeing. If there is potential for serious harm and the attending physician does not concur, or the attending physician refuses to document an explanation for disagreeing, the director of nursing and the consultant pharmacist contact the medical director. If the attending physician who disagrees is also the medical director, the consultant pharmacist and the director of nursing arrange a meeting with the medical director to discuss the issues. All parties	F 756			

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F 756	<p>Continued From page 59</p> <p>must come to agreement or a formal complaint should be initiated according to facility policy. If there is potential for serious harm to the resident, this process must be completed in a manner to ensure no actual harm occurs. The director of nursing or designated licensed nurse address and document recommendations that do not require a physician intervention, e.g., monitor blood pressure."</p> <p>5/20/19 (12:00 PM) - During an interview E2 (DON) stated, "I checked with them (pharmacy) this morning about the policy."</p> <p>5/20/19 (1:10 PM) - An interview with E37 (Consultant Pharmacist) confirmed the medication regimen review (MRR) policy did not include time frames for the various steps of the MRR process.</p> <p>2. Review of R59's clinical record revealed:</p> <p>1/21/19 - The medication regimen review indicated there was an irregularity, however the Note to Attending Physician / Prescriber was not in the record to determine if the physician responded.</p> <p>3/21/19 and 4/18/19 - Medication regimen reviews did not indicate whether or not there were any irregularities.</p> <p>5/17/19 (approximately 3:45 PM) - During an interview E2 (DON) provided a copy of the printout from March and April 2019 which showed that R59 did not have any pharmacy recommendations.</p> <p>5/20/19 (1:10 PM) - An interview with E37 (Consultant Pharmacist) acknowledged that the</p>	F 756			

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F 756	<p>Continued From page 60</p> <p>March and April 2019 MRR did not indicate whether there was a recommendation for these months. E37 stated, "I guess I have to pay closer attention to that."</p> <p>3. Review of R76's clinical record revealed:</p> <p>a. 7/9/18 and 9/12/18 - Physicians' orders included Depakote for the diagnosis of psychosis.</p> <p>Depakote is used to treat seizure disorders, certain psychiatric conditions (manic phase of bipolar disorder), and to prevent migraine headaches. It works by restoring the balance of certain natural substances (neurotransmitters) in the brain. https://www.webmd.com/drugs/2/drug-1788/depakote-oral/details</p> <p>4/26/19 - Physicians' orders changed the diagnosis for Depakote to mood disorder.</p> <p>b. April 2019 Medication Regimen Review (MRR) indicated there was no irregularity identified. However, there was a Note to Attending Physician / Prescriber with physician response in the record.</p> <p>5/20/19 (1:10 PM) - During an interview with E37 (Consultant Pharmacist) the classification for Depakote was discussed and revealed the medication should be a mood stabilizer. Also, E37 confirmed the April 2019 MRR indicated no recommendations yet there was one in the chart. E37 said, "I guess I have to pay closer attention to that."</p> <p>Cross Refer F684, Example 1</p> <p>4. Review of R329's clinical record revealed:</p>	F 756		

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F 756	Continued From page 61 5/2/19 - Telephone order entered in the computer for two blood pressure medications (amlodipine and metoprolol). The parameter for each medication included to hold the medication for systolic blood pressure greater than 110 or heart rate greater than 55 and should have been entered as LESS than... 5/3/19 - Review of the Admission Drug regimen review Reporting Form discovered the pharmacist failed to identify the incorrect parameter for the amlodipine. 5/16/19 (4:26 PM) - During an interview E2 (DON) confirmed the amlodipine parameters were not corrected until 5/10/19. Findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) on 5/21/19 during the exit conference beginning at 1:55 PM.	F 756		
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. §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: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that-- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a	F 758		

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F 758	<p>Continued From page 62</p> <p>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 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: Based on record review and interview, it was determined that, for three (R67, R76 and E332) out of five residents investigated for medication review, the facility failed to ensure the appropriate indication and monitoring of potentially adverse side effects and / or behavior monitoring for psychotropic medications. Findings include: Facility policy entitled Psychotropic Medication</p>	F 758		

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F 758	<p>Continued From page 63</p> <p>(revised 5/2017) included the procedure that "when a resident is prescribed any psychoactive medication, behavior monitoring and side effect monitoring will be in place. Behaviors should be specific for that resident and care planned accordingly.</p> <p>Cross Refer F756, Example 3</p> <p>1. Review of R76's clinical record revealed:</p> <p>July 2018 - May 2019 - Review of physicians' order report summary found:</p> <p>7/9/18 - Depakote ordered twice a day for psychosis. The diagnosis was changed to mood disorder on 4/25/19. This medication is used as a mood stabilizer so the diagnosis was not correct for over nine months before it was revised.</p> <p>7/9/18 - Seroquel ordered twice a day for psychosis.</p> <p>7/11/18 - Psychiatric consultation documented that R76 had a history of psychosis and dementia with behaviors. There was also a handwritten notation of "dementia with delusions."</p> <p>July 2018 - May 2019 - Review of behavior monitoring sheets for Seroquel discovered the behavior being assessed was "mood changes." The months of October, November and December 2018 included a handwritten notation of "argumentative, cursing" next to the pre-printed "mood changes" entry on the form. This drug was prescribed for psychosis, so monitoring for "mood changes" was not appropriate. There was no evidence that the facility monitored for delusions or identified if R76 had a particular type of delusion.</p>	F 758			

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F 758	<p>Continued From page 64</p> <p>5/20/19 (9:13 AM) - During an interview with E28 (RN, UM) to determine R76's specific symptoms warranting the use of Seroquel, E28 stated the resident was "resistive, mean, verbal...then (R76) would forget he/she was mean." Surveyor explained that Depakote was ordered as a mood stabilizer, yet the behavior monitoring sheet indicated psychosis. E28 offered no explanation.</p> <p>3/26/19 - Physicians' orders included an antidepressant daily for recurrent depression.</p> <p>March 2019 - review of behavior monitoring and adverse side effect monitoring sheets for the antidepressant found: - The behavior being monitored was reduced socialization. - Adverse side effect monitoring began 3/30/19 even though R76 started the medication on 3/27/19, three days before.</p> <p>For R76 the facility failed to: - ensure correct diagnosis for Depakote for nine months. - monitor appropriate behaviors for Seroquel for 10 months. - assess for adverse side effects of the antidepressant for three days after starting the medication.</p> <p>2. Review of R332's clinical record revealed: 4/29/19 - Admission to the facility.</p> <p>5/1/19 - Care plan for behaviors related to "disrobing, attempting to self transfer, becoming aggressive and refusing medications and meals" included the intervention to "Give (name of antianxiety medication) and Zyprexa</p>	F 758			

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F 758	<p>Continued From page 65 (antipsychotic) as ordered, document side effects and effectiveness."</p> <p>May, 2019 - Review of eMAR found R332 received the antipsychotic Haldol twice a day for delusional disorder from 5/11/19 to 5/14/19.</p> <p>5/14/19 - Physician progress note documented "not making much progress, DC (discontinue) Haldol and start Zyprexa (another antipsychotic).</p> <p>May, 2019 - Review of adverse side effect monitoring found it did not include monitoring for antipsychotic since 5/11/19.</p> <p>5/17/19 (9:06 AM) - An interview with E22 (RN, UM) confirmed the finding and immediately corrected the form to include antipsychotic medication.</p> <p>3. Review of R67's clinical records revealed:</p> <p>7/25/18 - Order for "Aimes test every 6 months", noting that an "AIMS" test refers to Abnormal Involuntary Movement Scale assessment, which is conducted to measure involuntary movements that sometimes develop as a side effect of treatment with antipsychotic medications.</p> <p>8/25/18 - Medication order: Abilify Tablet 2mg. Give 1 tablet by mouth one time a day related to delusional disorders, noting that Abilify is an antipsychotic medication.</p> <p>3/27/19 - Quarterly MDS conveyed that R67 received antipsychotic medications in seven out of seven days, along with an active diagnosis of psychotic disorder.</p> <p>5/20/19 - Review of computerized assessments</p>	F 758		

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F 758	Continued From page 66 disclosed that AIMS assessments were completed on 7/15/18, 7/25/18, 7/26/18 and 8/6/18. 5/20/19 - Review of "Next Assessment Due" under computerized Assessments reflects "AIMS - Abnormal Involuntary Movement Scale 192 days overdue - 11/6/18". The facility failed to ensure timely monitoring of potentially adverse side effects with regard to the administration of antipsychotic medications. Findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) on 5/21/19 during the exit conference beginning at 1:55 PM.	F 758			
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview it was determined that the facility failed to ensure that it was free of medication error rate of 5 percent or greater. During medication pass observation, on 5/16/19 and 5/17/19, four medication errors out of 30 opportunities were identified, resulting in a medication error rate of 13.3% and affecting two residents (R31 and R83). Findings include: The facility's policy titled, Administering Medications, with a revision date of 1/25/19 documented: Medications must be administered in accordance with the orders, including any	F 759			

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F 759	<p>Continued From page 67 required time frame. Medications must be administered within one hour of their prescribed time, unless otherwise specified.</p> <p>1. Review of R31's clinical record and observation of medication pass revealed:</p> <p>4/29/19 - A physician's order for Depakote Sprinkles Capsule Delayed Release Sprinkle 125 mg give 2 capsules by mouth in the afternoon at 2:00 PM for mood disorder.</p> <p>4/29/19 - A physician's order for Depakote Sprinkles Capsule Delayed Release Sprinkle 125 mg give 8 capsules by mouth in the evening at 9:00 PM for mood disorder.</p> <p>4/30/19 - A physician's order for Depakote Sprinkles Capsule Delayed Release 125 mg give 2 capsules by mouth in the morning at 8:00 AM for mood disorder.</p> <p>5/16/19 at 9:25 AM - During a random medication pass observation, E26 (LPN) administered 2 capsules of Depakote Sprinkles to R31. This medication was ordered to be given at 8:00 AM and was therefore late and given too close to the next ordered time (2:00 PM).</p> <p>2. Review of R31's clinical record and observation of medication pass revealed:</p> <p>4/27/18 - A physician's order for DuoNeb Solution 1 applicator full inhale orally every 3 hours around the clock related to chronic obstructive pulmonary disease.</p> <p>5/16/19 at 4:40 PM - During a random medication pass observation, E16 (LPN) administered DuoNeb to R31. This medication was ordered to</p>	F 759		

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F 759	Continued From page 68 be given at 3:00 PM and was therefore late and given too close to the next ordered time (6:00 PM). 3. Review of R83's clinical record and observation of medication pass revealed: 4/5/19 - A physician's order for Metoprolol Tartrate tablet 25 mg give 1 tablet by mouth two times a day related to high blood pressure at 10:00 AM and 9:00 PM. 5/17/19 at 12:03 PM - During a random medication pass observation, E28 (RN) administered Metoprolol Tartrate to R83. This medication was ordered to be given at 10:00 AM and was therefore late. 4. Review of R83's clinical record and observation of medication pass revealed: 5/9/19 - A physician's order for Oxybutynin Chloride tablet 5 mg give 1 tablet by mouth two times a day related to overactive bladder at 10:00 AM and 10:00 PM. 5/17/19 at 12:03 PM - During a random medication pass observation, E28 (RN) administered Oxybutynin Chloride to R83. This medication was ordered to be given at 10:00 AM and was therefore late. 5/17/19 at 3:00 PM - During an interview, E2 (DON) confirmed the above four medication errors occurred because of lateness. Findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) on 5/21/19 during the exit conference beginning at 1:55 PM.	F 759			
F 806	Resident Allergies, Preferences, Substitutes	F 806			

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F 806 SS=D	Continued From page 69 CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to accommodate, food preference for one (R84) resident, during random dining observation. Findings include: 5/16/19 at approximately 12:30 PM - During random lunch observation, R84 was served mashed potatoes with gravy. 5/16/19 at approximately 12:35 PM - The surveyor requested for R84's lunch meal ticket from E9 (Food Services Director). Shortly after this request, E9 provided the ticket, which documented no gravy on mashed potatoes. E9 observed R84's meal and confirmed R84 was served mashed potatoes with gravy, thus, the facility failed to accommodate R84's food preference of no gravy on mashed potatoes. Findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) on 5/21/19 during the exit conference beginning at 1:55 PM.	F 806			
F 809 SS=E	Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3)	F 809			

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F 809	<p>Continued From page 70</p> <p>§483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care.</p> <p>§483.60(f)(2) There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span.</p> <p>§483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and review of the meal times, it was determined that the facility failed to ensure, that the resident group agreed on the meal span, of more than fourteen (14) hours from dinner to breakfast the following day. Findings include: Review of the meal times revealed, that the first dinner meal was served in Sussex Unit at 5:30 PM and the same unit was served breakfast beginning at 7:30 AM. There was total of 15 hours between dinner and breakfast, thus, more than 14 hours from dinner to breakfast.</p> <p>5/15/19 beginning at approximately 10:30 AM - During the resident council meeting, nine anonymous residents, A1-A9, out of ten residents verbalized that they were not offered a nourishing snack at bedtime. In addition, the residents did</p>	F 809			

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F 809	Continued From page 71 not recall if they had, as a resident group, approved the meal times. 5/15/19 beginning at approximately 12:50 PM - An interview with E9 (Food Services Director, FSD) and E15 (Assistant DFS) confirmed that there was more than 14 hours between dinner and breakfast. E9 nor E15 was certain, if the resident group approved the current meal times. 5/15/19 at approximately 3:10 PM - E9 (FSD) verbalized to the surveyor, that the plan is to have a meeting with the resident group to review the meal times, as E9 was unable to determine if this was approved previously. Findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) on 5/21/19 during the exit conference beginning at 1:55 PM.	F 809			
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and	F 842			

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F 842	Continued From page 72 (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and	F 842			

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F 842	<p>Continued From page 73</p> <p>determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on clinical record review and interview, it was determined that the facility failed to ensure that medical records, for four (R119, R329, R330, and R332) out of 30 sampled residents, were complete and accurately documented. Findings include:</p> <p>1. The facility's Policy and Procedure (P & P) titled, Verbal Order, with a revision date of 1/25/19, documented: "4. The individual receiving the verbal order must write it on the physician's order sheet as v.o. (verbal order) or t.o (telephone order). 5. The individual receiving the verbal order will ...record the ordering practitioner's last name and his or her credential...c. record the date and time of the order..."</p> <p>Review of R119's clinical record and facility documents revealed:</p> <p>11/16/18 - R119 was admitted to the facility.</p> <p>2/13/19 and timed 4:13 PM - A Progress Note documented, that an urine specimen was obtained during the 7:00 AM - 3:00 PM shift on 2/13/19.</p> <p>2/14/19 and timed 12:28 PM - The results of an urinalysis (U/A, an urine test) was faxed to the facility.</p> <p>There was lack of evidence of an order for the</p>	F 842		

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F 842	<p>Continued From page 74 above urine test.</p> <p>2/16/19 and timed 12:47 PM - The results of the urine culture and sensitivity (A form of urine test) report faxed to the facility.</p> <p>There was lack of evidence of an order for the above urine test.</p> <p>5/17/19 at approximately 10:30 AM - An interview with E14 (RN, UM) confirmed that the facility failed to have a written order for the laboratory services. Shortly after this interview, the surveyor was provided a copy of the "Supervisor 24 Hour Report" for 2/12/19, in which during the 7:00 AM - 3:00 PM shift, which documented for R119, "...V.O. progressive U/A (A form of urine test)."</p> <p>5/20/19 at approximately 10:10 AM - An interview with E1 (NHA) confirmed that there was a lack of evidence of transcribing the order for the above urine test.</p> <p>Review of the clinical record and Admission Drug Regimen Review for three newly admitted residents (R329, 330 and 332) revealed the following:</p> <ol style="list-style-type: none"> 2. R329 did not have an Admission Drug Regimen Review Reporting Form in the record. 3. R330's Admission Drug Regimen Review Reporting Form was undated/untimed. The form was marked "Medication Reconciliation was not Completed" since "no transfer sheet received." 4. R332 had no date/time on the Admission Drug Regimen Review Reporting Form. <p>5/20/19 (9:25 AM) - An interview with E38</p>	F 842		

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F 842	Continued From page 75 (RNAC) confirmed R329's form was not in the record and that R330 an R332's form had no date / time. A follow-up interview (around 10:50 AM), when E38 provided a freshly printed copy of R329's admission drug regimen review documentation, the form included the date/time at the bottom of the page. E38 explained that the document was sent by email and when it was printed on the Kent (long term care) unit, the bottom got cut off and that the form may need adjusting so the entire form prints at the nursing station.	F 842		
F 880 SS=D	Findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) on 5/21/19 during the exit conference beginning at 1:55 PM. Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following	F 880		

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F 880	<p>Continued From page 76 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> <ul style="list-style-type: none"> (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: <ul style="list-style-type: none"> (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. <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.</p>	F 880		

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F 880	Continued From page 77 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, record review and interview it was determined that the facility failed to implement transmission-based precautions for one (R229) out of three residents on transmission-based precautions. Findings include: Review of R229's clinical record revealed: 5/14/19 (6:47 PM) - Nursing progress note documented admission to the Rehab unit after hospitalization and that R229 required contact precautions for an infection. 5/15/19 (9:06 AM - 9:20 AM) - Observation on Rehab unit of a container holding Personal Protective Equipment (PPE) hanging on the outside of R229's door. There was no sign indicating transmission-based (isolation) precautions was in place, nor a sign for visitors to see the nurse prior to entering. E35 (PT) escorted and showed a visitor to R229's room and the visitor entered the room without donning a disposable gown or gloves to prevent the spread of infection. 5/15/19 (9:21 AM) - An interview with E22 (RN, UM) confirmed that isolation rooms should have a sign posted. E22 stated R229 "came in last night and I have not had a chance to put one up. I guess they could have put one up last night." Findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) on 5/21/19 during the exit conference beginning at 1:55 PM.	F 880			
F 925	Maintains Effective Pest Control Program	F 925			

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F 925 SS=E	Continued From page 78 CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview it has been determined that the facility failed to maintain an effective pest control program. Findings include: The following observations of pests were conducted: 5/13/19 at 11:35 AM - flying insect observed around the Sussex Unit nurses station. 5/15/19 from approximately 10:30 AM to 11:30 AM - During a Resident Council meeting, a flying insect was observed flying around while residents were attending the meeting. 5/20/19 at 12:18 PM - A fly was observed around the lunch cart in the Sussex Unit hallway. 5/20/19 at approximately 3:17 PM - A fly was observed on R81's right hand, in the Sussex Unit, while R81 sat at a table in front of the unit's Nurse's Station. Surveyor informed E7 (RN) and E7 immediately verbalized that E7 would provide hand washing to R81. 5/21/19 at approximately 11:15 AM - A review of the Pest Control Log, in the Sussex Unit lacked evidence that the flying insect observed on 5/20/19 at approximately 3:17 PM was documented in the Pest Control Log and/or reported to the Maintenance Department.	F 925		
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F 925	<p>Continued From page 79</p> <p>5/21/19 at approximately 10:55 AM - An interview with E10 (RN) revealed that when staff observe pests within the unit, they can document in the Pest Control Log.</p> <p>5/21/19 at approximately 11:00 AM - An interview with E11 (CNA) was conducted. E11 was asked, if E11 observed an insect, how would this be reported. E11 related he/she was uncertain of the process.</p> <p>5/21/19 at approximately 11:07 AM - An interview with E12 (CNA) was conducted. E12 was asked, if E12 observed an insect, how would this be reported. E12 related he/she was uncertain of the process.</p> <p>5/21/19 at approximately 12:45 PM - The surveyor was provided a faxed copy of the current contracted pest control company's agreement by E6 (Facility Maintenance Director). E6 verbalized to report problems with pest in the unit, the staff may document in the Pest Control Log, located in each of the unit or contact the Maintenance Department directly. E6 confirmed he/she was not made aware of a fly in the Sussex Unit on 5/20/19.</p> <p>Findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) on 5/21/19 during the exit conference beginning at 1:55 PM.</p>	F 925		



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: Harrison Senior Living of Georgetown

DATE SURVEY COMPLETED: May 21, 2019

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
<p>3201</p> <p>3201.1.0</p> <p>3201.1.2</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 May 13, 2019 through May 21, 2019. The facility census the first day of the survey was 131. During this period an Emergency Preparedness Survey was also conducted by the State of Delaware's Division of Health Care Quality Long Term Care Residents Protection in accordance with 42 CFR 483.73. For the Emergency Preparedness survey no deficiencies were cited.</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 May 16, 2019: F565, F622, F623, F625, F644, F656, F657, F684, F688, F689, F690, F695, F697, F698, F713, F744, F756, F758, F759, F806, F809, F842, F880, and F925.</p>	<p>Disclaimer: Development and/or execution of this Plan of Correction does not constitute admission of or agreement with the facts and conclusions set forth on the 2567 survey report. Our plan of correction is prepared and executed to continually improve the quality of care and comply with all applicable State and Federal regulatory requirements.</p> <p>Cross reference to CMS form 2567 Dated 05/21/2019 for F565, F622, F623, F625, F644, F656, F657, F684, F688, F689, F690, F695, F697, F698, F713, F744, F756, F758, F759, F806, F809, F842, F880, and F925.</p>	<p>06/10/2019</p>

Provider's Signature Kemi C. Benjamin

Title Executive Director

Date 06/10/19