

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

PRINTED: 05/20/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085013	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/16/2019
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NAME OF PROVIDER OR SUPPLIER HILLSIDE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 810 SOUTH BROOM STREET WILMINGTON, DE 19805
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E 000	Initial Comments An unannounced annual/complaint survey was conducted at this facility from 1/8/19 to 1/16/19. The facility census the first day of the survey was 97. During this period, an Emergency Preparedness survey was also conducted by the State of Delaware Division of Health Care Quality, Office of Long Term Care Residents Protection in accordance with 42 CFR 483.73. For the Emergency Preparedness survey, no deficiencies were cited.	E 000		
F 000	INITIAL COMMENTS An unannounced annual, complaint, and emergency preparedness survey was conducted at this facility from 1/8/19 through 1/16/19. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census the first day of the survey was 97. The survey sample size was 46. Abbreviations/definitions used in this report are as follows: A&D ointment - ointment used to treat skin rashes, cuts and burns; ABD pad - absorbent wound dressing; ABT - antibiotic; Acetic acid - wound cleansing solution where it creates an acidic environment unfavorable for bacterial growth; ADON - Assistant Director of Nursing; Advance Directive - a written statement of a person's wishes regarding medical treatment, often including a living will, made to ensure those wishes are carried out should the person be unable to communicate them to a doctor; Albumin - lab test that measures protein in the	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 02/18/2019
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 blood; Ambulate - walk, move around; b/l - bilateral; Biological - made from a variety of natural sources-human, animal, or microorganisms. Biologicals are used to treat, prevent, or diagnose diseases and medical conditions; BID - twice a day; BMI / Body Mass Index - measure of body fat based on height and weight; BMP - set of eight tests that measure blood sugar and calcium levels, kidney function, and chemical and fluid balance; Braden assessment - tool used to determine risk for development of pressure ulcers; Calcium Alginate - dressing with calcium and sodium fibers made from seaweed; CBC / Complete Blood Count - blood test used to evaluate your overall health and detect a wide range of disorders, including anemia, infection and leukemia; Cerebral vascular disease- condition that limits or blocks blood supply to the brain; Chronic Kidney Disease / CKD - condition characterized by a gradual loss of kidney function over time; cm / centimeter - length of measurement; CNA - Certified Nurse's Aide; Code Status - refers to the level of medical interventions a patient wishes to have started if their heart or breathing stops; Congestive Heart Failure / CHF - heart unable to pump enough blood to meet the body's needs; Cognitively Intact - able to make own decisions; Corridor - hallway; D/C - discontinue; d/t - due to; Debridement - surgical removal of dead, damaged, or infected tissue to improve the healing potential of the remaining healthy tissue;	F 000		

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F 000	Continued From page 2 Diuretic - medicine that helps reduce the amount of water/excess fluid in the body; DNH - A do-not-hospitalize order, or DNH order, is a medical order written by a doctor. It instructs health care providers not to send a patient to the hospital; DNR - A do-not-resuscitate order, or DNR order, is a medical order written by a doctor. It instructs health care providers not to do cardiopulmonary resuscitation (CPR) if a patient's breathing stops or if the patient's heart stops beating; DON - Director of Nursing; Edema - retention of fluid into the tissue resulting in swelling; eMAR - electronic Medication Administration Record; EMR - Electronic Medical Record; ER - emergency room; Erythema - a diffuse redness over the skin caused by capillary congestion usually due to dilatation of superficial capillaries as a result of inflammation; Exudate - accumulation of fluids in a wound; Flagyl - antibiotic medication used to treat bacterial infections; Full Code - is a designation that means to intercede if a patient's heart stops beating or if the patient stops breathing; GFR - lab test that measures the level at which a resident's kidney is functioning; Hemiparesis - unilateral weakness of the entire left or right side of the body; Hemiplegia - half of body paralyzed; HR - heart rate; HS - at bedtime; Hydrogel - wound dressing to rehydrate non-viable skin tissue; Immediate Jeopardy (IJ) - situation in which the provider's noncompliance with one or more requirements of participation has caused, or is	F 000		

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F 000	Continued From page 3 likely to cause, serious injury, harm, impairment or death to a resident; Incontinent - loss of control of bowel function; Indurated - an area of hardened tissue; Intravascular - within a blood vessel; IV - intravenous/intravenously; Kerlix - gauze dressing; Lantus insulin - long acting man made hormone used to lower blood sugar levels; LPN - Licensed Practical Nurse; MASD / moisture associated skin damage - inflammation or skin erosion distributed diffusely and caused by prolonged exposure to a source of moisture such as urine, stool, sweat, wound drainage, saliva, or mucus. The injury starts at the top layer of the skin, and works inward leading to partial thickness. The tissue is pink or red in color; Macerated - softening of tissue by soaking in fluids; Malodorous - foul smelling; MD - Medical Doctor; MDS - Minimum Data Set (standardized assessment forms used in nursing homes); Mepilex - absorbent foam dressing; Multiple Sclerosis / MS - nervous system disease that affects the brain and spinal cord; Necrotic - black dead tissue; Nephrology - medical specialty that focuses on diseases of the kidneys; Nephrotoxicity - poisonous effect of medication on the kidneys; NHA- Nursing Home Administrator; NP - Nurse Practitioner; NSS / normal saline solution - solution used to clean wounds; Ombudsman - resident representative who investigates reported complaints and helps to achieve agreement between parties; Osteomyelitis - infection of the bone;	F 000		

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F 000	Continued From page 4 PCP - Primary Care Physician; PointClickCare / PCC - computer software used in long term care facilities; POA - Power of Attorney/resident's representative; POC - plan of care; PPE / personal protective equipment - equipment used to protect the wearer from infections (gown, gloves); Pressure Ulcer/Injury - sore area of skin over a boney prominence that develops when the blood supply to it is cut off due to pressure; PPD - Protein Purified Derivative/skin test used to help in diagnosing tuberculosis; PRN - as needed; Prosthetic - artificial body part; Puracol - collagen dressing that aides in wound healing; Purulent/purulence - containing or discharging pus; r/o - rule out; RD - Registered Dietician; Renal - relating to the kidneys; RN - Registered Nurse; RNAC - Registered Nurse Assessment Coordinator; Rt - resident; Sacrum/sacral - large triangular bone at base of spine; Santyl - ointment containing enzyme that helps remove dead tissue; Sepsis - potentially deadly medical condition characterized by a whole-body inflammatory state; Serum - blood; STAT - immediate; TAR/eTAR - electronic Treatment Administration Record; Trough - lowest concentration of a drug in the resident's bloodstream;	F 000		

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F 000	Continued From page 5 Tx - treatment; Tunneling - channels that extend from a wound into and through tissue or muscle; UA - urinalysis; Undermining - skin edges have lost supporting tissue under intact skin; UTI - urinary tract infection; Vancomycin / vanco - antibiotic used to treat certain kinds of bacterial infections; Vashe - cleansing wound solution; Z-guard ointment - skin protectant paste.	F 000			
F 678 SS=J	Cardio-Pulmonary Resuscitation (CPR) CFR(s): 483.24(a)(3) §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced by: Based on record review, interview, and review of other facility documentation as indicated, the facility failed to ensure that residents' code status' listed in their electronic medical record (EMR) matched their signed advanced directive document and code status sticker on the front of the paper chart. For two (R4 and R53) out of 97 sampled residents, the code status documented in their EMR were inconsistent with the code status documented in their paper charts. For R53, her EMR profile and physician orders documented that she was a full code, however, R53's paper chart had a red DNR sticker on the front and had a signed advanced directive documenting that she wanted to be a DNR. For R4, his EMR profile, physician orders, and code status sticker on the front of his paper chart documented that he was a DNR, however, his	F 678	R4 no longer resides at the facility. R53 code status has been changed from a full code to a DNR. An audit was completed on January 9,2019 by management to identify other residents' code status to verify that the physician order, the code status noted in Point Click Care (PCC) and the advance directive, if applicable, matched. The root cause of this deficient practice was not verifying the code status sticker on the front of the paper chart, the physician order, the code status noted on the EMR, and the advance directive (if one existed) all matched.	3/6/19	

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F 678	<p>Continued From page 6</p> <p>signed advanced directive had conflicting information and stated on the same document that he wanted to be a full code and wanted to be a DNR. Staff were interviewed regarding how they check a resident's code status, and they stated they would check the EMR, and if that were not available, they would refer to the chart. The facility failed to have a system in place for staff to obtain residents' accurate code status, which placed these residents in an immediate jeopardy situation. The IJ was identified on 1/9/19 at 11:58 AM and was abated on 1/9/19 at 4:20 PM. Findings include:</p> <p>The facility's Health Care Decision Making policy (effective 6/1/96, revised 1/1/13) stated, "It is the right of all patients to participate in their own health care decision making, including the right to decide whether they wish to accept or refuse life prolonging measures or other treatments."</p> <p>1. Review of R53's clinical record revealed:</p> <p>7/22/15- R53 signed an advanced directive indicating that she wanted to be a DNR.</p> <p>1/9/19- During the initial pool record review it was revealed that R53's EMR profile and physician orders indicated that she was a full code. R53's EMR had a scanned copy of her 7/22/15 advanced directive indicating she wanted to be a DNR. R53's paper chart was observed to have a red DNR sticker on the front and had a copy of her 7/22/15 advanced directive indicating she wanted to be a DNR.</p> <p>1/9/19 10:38 AM- During an interview, E18 (LPN), a nurse who was working on R53's floor, stated that to find a code status in an emergency, she would check the EMR. If the EMR was down, she</p>	F 678	<p>The code status stickers were removed from resident paper charts. Code status was added to all resident paper charts in the first position on a form entitled "Order Details." The Nurse Practice Educator (NPE) educated staff on this systemic change and how to check the code status when the EMR is inoperable.</p> <p>An audit of the residents' code status matching physician order, an advance directive (if one exists) and the paper chart will be done daily by the Administrator and/or designee until the facility reaches 100% success over three consecutive evaluations. Then an audit will be done three times a week until the facility reaches 100% success over three consecutive evaluations. Then an audit will be done once a week until the facility reaches 100% success over 3 consecutive evaluations. Finally, one more audit will be done a month later. If the center reaches 100% compliance, the Quality Assessment and Performance Improvement (QAPI) Committee will conclude that the center has successfully addressed the issue.</p>	

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F 678	<p>Continued From page 7 would check the paper chart.</p> <p>2. Review of R4's clinical record revealed:</p> <p>7/26/18- R4 signed an advanced directive indicating that he wanted to be a full code and wanted to be DNR on the same document. R4 and two witnesses signed R4's advanced directive document, which contained the conflicting information. The facility failed to seek clarification of the document to indicate R4's wishes regarding his code status. A new document was never created indicating what R4 wanted regarding his code status.</p> <p>1/9/19- During the initial pool record review it was revealed that R4's same advanced directive, which contained conflicting code status information, was located in his paper chart and a scanned copy was in his EMR. Despite R4 not having a confirmed code status, his EMR profile and physician orders indicated he was a DNR and DNH. In addition, on the front of R4's paper chart there was a red DNR sticker.</p> <p>1/9/19 10:29 AM- During an interview, E10 (LPN), a nurse who was working on R4's floor, stated that to find a code status in an emergency, she would check the EMR and if the EMR was unavailable she would go to the paper chart.</p> <p>Immediate Jeopardy was identified per review of R4 and R53's records. The following information relates to both residents:</p> <p>1/9/19 11:58 AM- Findings were reviewed with E1 (NHA), E2 (DON), and E17 (Social Worker) and they were advised that an IJ was identified when two current residents were found to have inconsistent code status information on their</p>	F 678			

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F 678	<p>Continued From page 8 electronic and paper charts.</p> <p>1/9/19 1:12 PM- E1 (NHA), E2 (DON), and E17 (Social worker) confirmed findings. E1 (NHA) stated that it was confirmed that R53 wanted to be a DNR and that her EMR indicated she was a full code. E1 (NHA) stated that a correction would be made to her EMR code status. E1 (NHA) stated that R4's advanced directive had conflicting information. Staff subsequently communicated with R4 and it was confirmed that he wanted to be a DNR. E17 (Social Worker) stated the ombudsman would update R4's advanced directive to correct his code status on 1/10/19.</p> <p>1/9/19 4:20 PM - At this time, the survey team received an approved plan of correction that included: correction of code status' on identified residents after a whole facility audit was done to verify that the physician order, the code status noted on the EMR, and the advanced directive (if one existed) all matched, staff were educated on obtaining code status and verifying advanced directives, DNR and full code stickers were to be removed from resident paper charts, code status was added to all resident paper charts in the first position on a form entitled "Order Details" and staff were educated that this was how to check code status' when the EMR was inoperable, and audits and monitoring would be completed on the above measures. The IJ was abated at this time.</p> <p>Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 1/16/19 at 6:15 PM.</p> <p>The facility failed to maintain consistent documentation of R4 and R53's code status leading to the possibility that the incorrect code</p>	F 678		

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F 678	Continued From page 9	F 678			
F 686 SS=G	<p>Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)</p> <p>§483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that-</p> <p>(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and</p> <p>(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and review of the clinical record, facility documentation and professional clinical resources as indicated, it was determined that for one (R19) out of 2 sampled residents, the facility failed to ensure that a resident received the necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. R19 had a history of a healed sacral pressure ulcer (PU) and was being treated for MASD on the buttocks since 1/12/18. On 3/14/18, the facility identified a skin alteration on R19's sacrum, however, they failed to do a thorough baseline assessment, including staging of R19's sacral PU. From 3/14/18-4/18/18, facility documentation lacked evidence of thorough assessments and effectiveness of the wound treatment in place. This resulted in harm when R19 was diagnosed with an unstageable</p>	F 686	<p>R19 Stage IV pressure ulcer to sacrum has healed. R19 remains at high risk for developing MASD and pressure ulcers. R19 Braden scale completed. E22 is no longer practicing at the facility.</p> <p>Residents are at risk for developing MASD and/or pressure wounds if risk factors such as age, incontinence, limited mobility, nutritional deficits exists. The licensed nurse performs weekly skin checks on residents to identify new or worsening skin alterations. Braden assessments are done on admission and quarterly to identify risk factors. Skin alterations identified are placed on the skin integrity report upon initial identification of an alteration in skin integrity, weekly and with a decline of a</p>		3/6/19

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F 686	<p>Continued From page 10</p> <p>sacral PU on 4/18/18. On 4/23/18, R19 was sent to the hospital at the request of R19's POA with a diagnosis of an infected sacral pressure ulcer. R19 continued treatment with IV antibiotics and underwent a debridement of the sacral pressure ulcer in the hospital. Findings include:</p> <p>According to the National Pressure Ulcer Advisory Panel (April 2016), the stages of pressure injuries/ulcers (categorization system used to describe the severity of PUs):</p> <p>Stage I (1) - a reddened area of intact skin usually over a boney prominence, that when pressed does not turn white. This is a sign that a PU is starting to develop.</p> <p>Stage II (2) - skin blisters or skin forms an open sore. The area around the sore may be red and irritated. This stage should not be used to describe MASD.</p> <p>Stage III (3) - skin develops an open, sunken hole called a crater. There is damage to the tissue below the skin. Undermining may occur.</p> <p>Stage IV (4) - ulcer has become so deep that there is damage to the muscle and bone and sometimes to tendons and joints.</p> <p>Unstageable - Tissue loss in which actual depth of the ulcer is unable to be determined due to the presence of slough (yellow, tan, gray, green or brown dead tissue) and/or eschar (dead tissue that is tan, brown or black and tissue damage is more severe than slough in the wound bed).</p> <p>The facility's policy entitled Skin Integrity Management, last revised on 11/28/16, stated, "...Staff continually observes and monitors patients for changes and implements revisions to the plan of care as needed...Practice Standards: ...3.2 Perform skin inspection...weekly. Document on Treatment Administration Record (TAR) or in PointClickCare (PCC). 3.3 Perform wound</p>	F 686	<p>wound. The licensed nurse will perform daily monitoring of pressure ulcers and/or pressure ulcer wound dressings for presence of complications or decline.</p> <p>The root cause of this deficient practice is the failure to accurately identify R19's skin alteration and to accurately document the decline or worsening of this skin alteration. Also, nursing staff failed to discontinue a previous treatment order when a new treatment order was initiated and to consistently monitor the effectiveness of the wound treatment.</p> <p>The NPE will educate the licensed nursing staff on staging of pressure ulcers, weekly skin assessment accuracy, what to observe for and reporting observations, discontinuing an old treatment order when a new treatment is ordered, the signing off of treatments, notification of responsible party of new skin alterations and new treatments, and accurate completion of the skin integrity report. Also, the NPE will educate CNA's on notification of skin change, including pressure ulcers, what to observe for and reporting observations.</p> <p>Residents with pressure ulcers will be monitored daily by the DON and/or designee for decline in status and for accuracy of wound assessment and documentation including treatment order. This monitoring will be done daily until the facility consistently reaches 100% success over three consecutive evaluations. Then, the monitoring will be done three times a week until the facility</p>	

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F 686	<p>Continued From page 11</p> <p>observations and measurements and complete Skin Integrity Report...upon initial identification of altered skin integrity, weekly, and with anticipated decline of wound. 3.4 Perform daily monitoring of wounds or dressings for presence of complications or declines and document...".</p> <p>Review of R19's clinical record revealed:</p> <p>8/27/11 - R19 was admitted to the facility with diagnoses that included Multiple Sclerosis and a history of skin breakdown, including a sacral pressure ulcer.</p> <p>3/15/13 (last revised 9/30/14) - R19 was care planned for exhibiting or at risk for alterations in functional mobility related to Multiple Sclerosis. Interventions included, but were not limited to:</p> <ul style="list-style-type: none"> - observe for signs of breakdown, redness, edema and notify rehab/physician of any changes in skin integrity or complications; - perform skin check when placed back in bed; and - turn and reposition every 2 hours and as needed, check skin for redness. <p>11/9/11 (last revised 11/2/18) - R19 was care planned for prevention and treatment of pressure wounds...at risk for skin breakdown as evidenced by a diagnosis of Multiple Sclerosis, incontinence and a history of pressure ulcers. Interventions included, but were not limited to:</p> <ul style="list-style-type: none"> - assist resident in turning and repositioning every 2 hours with skin checks; - Braden assessments; and - weekly skin assessment by a licensed nurse. <p>1/18 through 2/9/18 - Review of the weekly skin assessments revealed that R19 was identified with the following skin injury/wound(s) on:</p>	F 686	<p>consistently reaches 100% success over three consecutive evaluations. Then, the monitoring will be done once a week until the facility reaches 100% success over three consecutive evaluations. Finally, one more audit will be done a month later. If the center reaches 100% compliance, the QAPI Committee will conclude that the center has successfully addressed the issue.</p>	

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F 686	<p>Continued From page 12</p> <ul style="list-style-type: none"> - 1/12/18 at 12:12 PM - MASD on buttocks; - 1/19/18 at 11:46 AM - MASD on buttocks; - 1/26/18 at 1:05 PM - MASD on buttocks; - 2/2/18 at 1:07 PM - MASD on buttocks; and - 2/9/18 at 10:24 AM - MASD (unidentified location). <p>2/9/18 at 7:20 PM - A physician's order stated, "Diet consult: low protein, low albumin".</p> <p>2/16/18 through 2/28/18 - Review of the weekly skin assessments revealed that R19 was identified with the following skin injury/wound(s) on:</p> <ul style="list-style-type: none"> - 2/16/18 at 8:54 AM - MASD (unidentified location); and - 2/23/18 at 11:17 AM - MASD on buttocks. <p>2/28/18 at 12:45 PM - A nurse's note stated, "weight warning...5.6% change over 30 days...Eating 100% for meals. Receiving HS snack. BMI=Normal. No concerns. Not on a diuretic. Will continue to monitor. RD, MD, Resident aware."</p> <p>3/18 - Review of the March 2018 CNA documentation report revealed that a mixture of Z-guard ointment and A&D ointment was being applied to R19's buttocks after each incontinent episode and as needed and R19 was being turned and repositioned every 2 hours.</p> <p>3/2/18 at 7:32 AM - A weekly skin assessment revealed that R19 was identified with MASD on the buttocks.</p> <p>3/8/18 at 5:03 PM - A nurse's note stated that R19's skin was "intact" and R19 was incontinent of bowel. Despite R19 receiving ongoing treatment for MASD on his buttocks, the facility</p>	F 686			

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F 686	<p>Continued From page 13 documented that his skin was intact.</p> <p>3/9/18 at 9:05 AM - A weekly skin assessment revealed that R19 was identified with MASD on his buttocks.</p> <p>3/9/18 at 12:04 PM - A nurse's note stated, "weight warning...6.1% change over 30 days...Eating 100% for meals. Receiving HS snack. BMI=normal. No concerns. RD, MD, Resident aware."</p> <p>3/14/18 at 10:22 AM - A physician's order stated, "Hydrogel...Apply to Sacrum topically every day as needed for MASD. Cleanse MASD with NSS, pat dry, apply hydrogel and cover with ABD pad daily and PRN until healed...". Despite the facility treating R19's buttocks for MASD with a mixture of Z-guard and A&D ointment, the facility failed to identify and assess R19's sacrum as a new skin alteration in a pressure area. When the physician ordered a new treatment to the sacrum on 3/14/18, the facility failed to initiate and complete a Skin Integrity Report for R19's sacrum, that included identifying the type of wound, location, staging, presence of pain, appearance, measurements, undermining, tunneling, drainage, surrounding tissue, wound edges and odor. The facility also lacked evidence that R19's POA was notified of the new skin alteration on his sacral area and the treatment ordered.</p> <p>3/15/18 through 3/31/18 - Review of R19's eTAR revealed that Hydrogel treatment was applied to his sacrum daily. However, R19's clinical record during this timeframe lacked evidence of any pressure ulcer monitoring and assessments of his sacral area and whether the Hydrogel treatment was effective.</p>	F 686		

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F 686	<p>Continued From page 14</p> <p>3/16/18 through 3/23/18 - Review of the weekly skin assessments revealed that R19 was identified with the following skin injury/wound(s) on:</p> <ul style="list-style-type: none"> - 3/16/18 at 8:15 AM - MASD on buttocks. - 3/23/18 at 10:36 AM - Sacrum. <p>The facility failed to identify an issue with the sacral area on the 3/16/18 weekly skin assessment and failed to identify the type of issue with the sacrum on the 3/23/18 skin assessment.</p> <p>3/26/18 at 12:47 PM - A progress note, written by E22 (NP), stated that R19 was seen and examined. E22 stated that R19 had a recent weight loss, but remained stable with dietary interventions. E22 stated that R19 preferred to stay in his room despite encouragement. R19's skin abnormality was assessed and stated that his skin was warm, dry and intact. The facility failed to identify and follow-up on R19's skin integrity issues on his buttocks that had been ongoing since January 2018 and a new area identified on his sacrum with a treatment ordered on 3/14/18.</p> <p>3/30/18 at 1:01 PM - A weekly skin assessment revealed that R19 was identified with MASD. The assessment lacked evidence of the MASD's location.</p> <p>4/1/18 through 4/13/18 - Review of R19's eTAR revealed that the Hydrogel treatment, ordered on 3/14/18, was applied to his sacrum daily. Despite the daily treatments to R19's sacrum, the clinical record lacked evidence of any assessments or monitoring to determine if the treatment was effective.</p> <p>4/1/18 through 4/22/18 - Review of the April 2018 CNA documentation report revealed that a</p>	F 686		

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F 686	<p>Continued From page 15</p> <p>mixture of Z-guard ointment and A&D ointment was applied to R19's buttocks after each incontinent episode and as needed and R19 was being turned and repositioned every 2 hours.</p> <p>4/1/18 at 1:11 PM - A nutritional assessment stated that R19 had no pressure ulcers and "...MASD to buttocks noted...treatment in place. Per nursing, MASD is not healing, resident is resistive to turning or repositioning...". Despite documentation by the CNAs that R19 was turned and repositioned every 2 hours, the clinical record lacked evidence when R19 resisted turning and repositioning.</p> <p>4/2/18 - A quarterly MDS assessment stated that R19 had moderate cognitive impairment, required extensive assistance of one staff person for bed mobility, required total assistance of one person for toilet use, had bilateral lower extremity impairment, was always incontinent of bowel, had active diagnoses that included Multiple Sclerosis, was at risk for pressure ulcers, had no current pressure ulcer, had MASD, and had a pressure reducing device for his chair and bed. The facility failed to identify that there was a skin integrity issue of the sacral area, a pressure point.</p> <p>4/2/18 at 12:18 AM - A comprehensive nursing assessment, which included a Braden assessment, was completed. The Braden assessment stated that R19 was "completely immobile - does not make even slight changes in body position by self...Bedfast - confined to bed...Problem - frequently slides down in chair or bed...Very moist - incontinent once a shift...Skin impairment(s)...(checked) not present...". The facility failed to capture R19's current skin integrity issues on his buttocks and sacrum in the Braden assessment.</p>	F 686		

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F 686	<p>Continued From page 16</p> <p>4/6/18 and untimed - A progress note stated, "...For weight support and healing of wounds, he gets supplemental shakes...Hydrogel Gel...Vitamins A & D Ointment Apply to b/l buttocks topically as needed for MASD...Physical Exam General:...alert and oriented to self...Bedbound...3/12/18 Albumin 3.1 Protein, Total 6.4...2/5/18...Albumin 3.2, total protein 6.1...General weakness and debility present...patient is doing reasonably well..."</p> <p>4/6/18 through 4/13/18 - Review of the weekly skin assessments revealed that R19 was identified with the following skin injury/wound(s) on: - 4/6/18 at 8:25 AM - MASD; - 4/13/18 at 2:07 PM - MASD. The facility failed to document the location of the MASD on both assessments.</p> <p>4/13/18 (untimed) - A verbal physician's order by E4 (Physician) stated, "Cleanse sacrum MASD with NSS, pat dry, apply puracol and cover with ABD pad daily and PRN until healed every day shift for sacrum AND every 8 hours as needed for sacrum...". Despite the change in treatment to R19's sacrum on 4/13/18, the clinical record lacked evidence of any assessment of the sacrum performed by either the physician/NP and/or nursing staff.</p> <p>4/14/18 through 4/17/18 - Review of R19's eTAR revealed that puracol treatment was applied to his sacrum daily. Despite daily treatments to R19's sacrum, the clinical record lacked evidence of any assessments or monitoring to determine if the treatment was effective.</p> <p>4/18/18 and untimed - A Skin Integrity Report</p>	F 686		

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F 686	<p>Continued From page 17 (completed by a nurse) stated:</p> <ul style="list-style-type: none"> - Location: marked with an "X" on sacral area; - Type of Wound: Unstageable; - Presence of Pain: not applicable; - Appearance: necrotic (eschar) 100%; - Length: 13.7 cm; - Width: 16 cm; - Depth: 1.5 cm; - Undermining: at 12 o'clock and 2 o'clock; - Drainage: Purulent moderate; - Surrounding Tissue: macerated, inflamed/indurated; - Wound Edges: macerated; - Odor: yes. <p>4/18/18 at 10:30 AM - A physician order, written by E22 (NP), stated to "clean sacral wound with Vashe, apply Flagyl powder, then apply a thin layer of Santyl. Pack...with ABD pad BID and PRN. Low air pressure mattress."</p> <p>4/18/18 at 1:02 PM - A progress note, written by E22 (NP), stated, "...54 year old...with MS...seen and examined d/t sepsis...Today morning (sic) during medpass, Rt was noted with lethargia (sic), confusion...fever of 101.7, HR 120...Discussed with PCP and sepsis work up ordered with STAT labs, chest Xray, UA...Urine appears cloudy and segmented. Infection could be a(sic) related to UTI...Rt is oriented x1, very lethargic and falls to sleep while conversing...Non-verbal...Integumentary: Rash yes, Abrasions yes...difficulty speaking yes...Skin Abnormality: assessed, warm: yes, dry: yes...Fiscussed (sic) POC with E4 (Physician) and is agreeable...". There was no evidence that E22 evaluated R19's sacral wound and considered that it could be the source of R19's sepsis.</p>	F 686		

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F 686	<p>Continued From page 18</p> <p>4/18/18 at 2:23 PM - A physician's order, written by E22 (NP), stated to discontinue the sacrum treatment ordered on 4/13/18.</p> <p>4/18/18 at 3:11 PM - A nurse's note stated, "CNA notified me this morning at (7:30 AM) that this resident did not seem like himself. This nurse assessed him and called NP who came down to assess him..."</p> <p>4/19/18 at 9:30 AM - A physician order stated, "...Continue Santyl BID to sacral wound. D/C Flagyl powder order to sacral wound."</p> <p>4/21/18 (untimed) - A progress note, written by E22 (NP), stated that R19 was seen and examined. However, the progress note failed to address the current status of R19's unstageable sacral pressure ulcer and treatment effectiveness.</p> <p>4/21/18 at 10:30 AM - A physician order stated, "X-ray of sacrum to r/o Osteomyelitis."</p> <p>4/21/18 at 1:51 PM - A physician order by E22 (NP) stated, "(1) Pressure ulcer to sacrum: cleanse w/ acetic acid, rinse w/ NSS, apply Santyl, then Calcium Alginate, cover w/ foam dressing, then ABD pads every day and PRN (foam dressing and ABD pads)...". Despite this physician's order changing R19's wound treatment to his sacrum and the treatment being placed on the eTAR, the facility failed to identify that R19 now had 2 wound treatments ordered for his sacrum (4/19/18 and 4/21/18). The facility continued wound treatment with the 4/19/18 physician's order, without seeking clarification of which wound treatment to use.</p> <p>4/22/18 at 3:22 AM - The X-ray report of the</p>	F 686			

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F 686	<p>Continued From page 19 sacrum stated there was no Osteomyelitis.</p> <p>4/22/18 - Review of the eTAR revealed that R19's sacral wound treatment was not signed off as done at 9 AM. The scheduled 9 PM wound treatment had "NN" signed off by nursing staff, which indicated to "See Nurse Notes". The 4/22/18 nurse's notes lacked evidence of any documentation with respect to R19's sacral wound. The facility failed to provide R19 with sacral wound treatment on 4/22/18 and they failed to document a note for the 9 PM wound treatment.</p> <p>4/23/18 at 1 PM - A physician order, written by E22 (NP), stated, "Send to ER for Evaluation."</p> <p>4/23/18 at 4:20 PM - R19 arrived at the hospital by non-emergency ambulance transport and was admitted.</p> <p>4/23/18 at 5:23 PM - The hospital record stated, "...Physical Exam...Skin: 14 cm x 14 cm unstageable sacral decubitus ulcer (same as PU) with exposed bone soiled with stool (sic) patient is incontinent of stool...Per the family, they have been told that he had a relatively small ulcer that was being treated with IV antibiotics at the long-term care facility. However, today he was not speaking to them which was worsening compared to his declining interactions over the last week. Family asked to see the ulcer and it was significantly worse (sic) they would like to believe, at which point they requested that he come here for further evaluation...He did have an x-ray done of his pelvis which they were told did not show any signs of osteomyelitis...Patient has extensive ulceration over his lower back with obvious sacral exposure, stool has tracked from his diaper into his wound..."</p>	F 686			

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F 686	<p>Continued From page 20</p> <p>4/24/18 at 8:04 AM - A hospital consult by C1 (Plastic Surgeon) stated, "...Wound assessment:...sacrum; size: 9cm x 5cm x 1.2cm; description: Stage IV (4) ulcer of the sacrum with extensive necrotic tissue and sloughing. No tenderness to palpation, mild erythema along borders, no edema or warmth. Kerlix and Mepilex dressing is soaked with exudate and purulence. Edges macerated and undermined. Malodorous...Plan: Continue antibiotic treatment...Will likely need debridement..."</p> <p>4/25/18 - The hospital records stated that R19's Stage IV (4) sacral wound was debrided.</p> <p>1/16/19 at 10:43 AM - During an interview, E4 (Physician) stated that she was told about R19's sacral wound on Friday night, 4/20/18. E4 stated that E22 (NP) did not look at the wound. When asked if she saw R19 during the time he was being treated for sepsis (4/18/18 - 4/23/18), E4 stated that she could not remember if she saw the resident. E4 stated that R19's "medical care was driven by the (managed care partner), not me".</p> <p>1/16/19 at 6:30 PM - Findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) during the Exit Conference.</p> <p>1/23/19 - Review of additional documentation provided by the facility revealed a text message sent 4/18/18 (untimed) from E22 (NP) to E4 (physician), which stated, "...Meanwhile we noticed his sacral wound looks worse and unstageable but no indication of infection or purulent discharge". This description contradicts the facility's wound assessment by a nurse on 4/18/18 which stated 100% necrotic, moderate</p>	F 686			

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F 686	Continued From page 21 purulent drainage and odor. The facility failed to provide pressure ulcer treatment and services to R19 by the failure to: - identify the sacrum as a pressure ulcer and perform a baseline pressure ulcer assessment on 3/14/18; - monitor and assess R19's sacral pressure ulcer from 3/14/18 through 4/23/18 for signs and symptoms of a decline, infection and to determine if the treatments ordered on 3/14/18, 4/1/18, 4/14/18, 4/18/18 and 4/19/18 were effective; and - seek clarification of which wound treatment to use when 2 wound treatment orders (4/19/18 and 4/21/18) were in place and the facility continued with the 4/19/18 wound treatment until R19 was hospitalized on 4/23/18. R19 was identified with an unstageable sacral PU on 4/18/18 and admitted to the hospital on 4/23/18 with a diagnosis of an infected sacral PU.	F 686			
F 688 SS=E	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a	F 688		3/6/19	

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F 688	<p>Continued From page 22</p> <p>reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, it was determined that for one (R40) out of two sampled residents, the facility failed to provide the restorative services ordered for R40 to maintain or improve his mobility, unless unavoidable; the facility failed to follow R40's restorative walking program to ambulate R40 two times a day, seven days a week. Findings include:</p> <p>Review of R40's clinical record revealed:</p> <p>R40 was admitted to the facility on 1/11/11 with diagnoses that included hemiplegia and hemiparesis following cerebrovascular disease.</p> <p>Review of R40's 11/6/18 annual MDS revealed R40 needed one person limited assistance to walk in the corridor.</p> <p>Review of R40's CNA tasks revealed that R40 was on a restorative walking program and staff were to ambulate R40 two times daily for seven days a week for 20 feet.</p> <p>R40's November 2018 Documentation Survey report lacked evidence that staff walked R40 on 15 out of 60 opportunities.</p> <p>R40's December 2018 Documentation Survey report lacked evidence that staff walked R40 on 21 out of 62 opportunities.</p> <p>R40's January 2019 Documentation Survey report lacked evidence that staff walked R40 on 13 out of 30 opportunities.</p> <p>On 1/8/19 at 9:01 AM, during an interview, R40</p>	F 688	<p>R40 will be evaluated by physical therapist for restorative nursing recommendation. This recommendation will be communicated to R40.</p> <p>An audit of current residents will be completed by the MDS Coordinator and/or designee and will include review by the physical therapist to determine the need for restorative nursing.</p> <p>The root cause of this deficient practice is that the certified nursing assistants (CNA's) failed to consistently follow and/or document the restorative walking program.</p> <p>CNA's will be educated on the restorative walking program including consistent documentation on the ADL Point of Care (PCC).</p> <p>The NPE and/or designee will audit the ADL Point of Care (PCC) documentation to evaluate whether residents are being walked according to the restorative nursing recommendation. This will be done daily over three consecutive evaluations until the facility reaches 100% success. Then, the audit will be completed three times a week until the facility reaches 100% success at three consecutive evaluations. Then the audit will be completed once a week over three consecutive evaluations until the facility reaches 100% success. Then the audit will be measured one more time a month</p>	

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F 688	Continued From page 23 indicated that he wanted to get up and take a walk. R40 stated that the nurses don't take him for a walk. On 1/15/19 at 11:19 AM, during an interview, E5 (LPN) stated that R40 could walk by holding onto the rail in the hallway. E5 stated that R40 was not on a walking schedule, but he could ask the nurse if he wanted to get up and walk and they would get him up. The facility failed to ensure that the restorative walking program for R40 was consistently followed, in order that R40 maintained his highest practicable mobility.	F 688	later. If the facility reaches 100% success, the QAPI committee can conclude that the facility successfully addressed the problem	
F 710 SS=D	Resident's Care Supervised by a Physician CFR(s): 483.30(a)(1)(2) §483.30 Physician Services A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. A physician, physician assistant, nurse practitioner, or clinical nurse specialist must provide orders for the resident's immediate care and needs. §483.30(a) Physician Supervision. The facility must ensure that- §483.30(a)(1) The medical care of each resident is supervised by a physician; §483.30(a)(2) Another physician supervises the medical care of residents when their attending physician is unavailable. This REQUIREMENT is not met as evidenced	F 710		3/6/19

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F 710	<p>Continued From page 24</p> <p>by:</p> <p>Based on interviews and review of the clinical record and other documentation as indicated, it was determined that for one (R19) out of 2 sampled residents, the facility failed to ensure that R19's medical care was supervised by a physician. The facility failed to ensure that R19's medical care was supervised by a physician and/or the physician's designee when his sacral pressure ulcer worsened from 3/14/18 to 4/23/18, despite R19's sacral wound treatment orders being changed 5 times. R19's sacral pressure ulcer (PU) became infected and unstageable requiring debridement in the hospital. There was no evidence in the clinical record that R19's sacral PU was assessed by E4 (physician) or E22 (NP) in the nursing facility prior to R19 being hospitalized. Findings include:</p> <p>Cross refer to F686.</p> <p>The facility's policy entitled Physician Services, effective 3/1/18, stated, "...Purpose: To ensure medical supervision of the care of each patient by a physician throughout the patient's stay...Standards and Procedures for all licensed independent practitioners...Visits...7. The practitioner must write a progress note to the patient chart at the time of each visit. The progress note must state the current medical problems and reflect the patient's present medical condition, as well as contain a rationale for starting, continuing, and discontinuing...other treatments...9. The practitioner must provide appropriate medical supervision of the patient under his/her care. 10. The practitioner will provide appropriate and timely medical oversight and management for the patient, including periodic reassessment of the patient's problems, medical condition, and plan of care..."</p>	F 710	<p>R19 physician will be educated by the Senior Vice President of Medical Affairs regarding the failure to assess and supervise R19 medical care regarding R19 pressure ulcer. E22 is no longer practicing at the facility.</p> <p>Residents with pressure ulcers under E4 medical supervision have the potential to be affected by this deficient practice. The newly hired Medical Director will be responsible to ensure E4's effective physician participation in care processes such as assessment, diagnosis, treatment and documentation.</p> <p>The root cause of this deficient practice is that E4 failed to assess and supervise R19 pressure ulcer. Licensed nursing staff failed to discontinue an old treatment order when a new treatment had been ordered.</p> <p>The Senior Vice President of Medical Affairs will educate E4 on the need to assess and supervise pressure ulcers. The NPE will educate the licensed nursing staff on discontinuing an old treatment when a new treatment is ordered.</p> <p>The medical supervision of E4's residents with pressure ulcers will be monitored two times a month for two months by the Senior Vice President of Medical Affairs who will report to the QAPI Committee his findings. The QAPI Committee with the Senior Vice President of Medical Affairs will determine the need for further audits. The DON and/or designee will monitor the</p>		

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F 710	Continued From page 25 Review of R19's clinical record revealed: 3/14/18 at 10:22 AM - A verbal physician's order by E4 (Physician) stated to apply Hydrogel to the sacrum every day and PRN for MASD until healed. R19's clinical record lacked evidence that R19's sacrum was examined by E4 (physician) on 3/14/18. 3/26/18 at 12:47 PM - A progress note, written by E22 (NP), stated that R19 was seen and examined. R19's skin was noted to be warm, dry and intact. Despite a daily treatment order for R19's sacrum, the clinical record lacked evidence that E22 was aware of R19's sacral wound. 4/6/18 (untimed) - A progress note, written by E4 (Physician), lacked evidence that R19's skin, including the sacral wound with a daily treatment ordered, was examined. 4/13/18 (untimed) - A verbal order by E4 (Physician) stated to apply Puracol to the sacrum daily and PRN for MASD until healed. Despite the change in treatment to R19's sacrum on 4/13/18, the clinical record lacked evidence of E4 (Physician) examining R19's sacrum. 4/18/18 and untimed - A Skin Integrity Report (completed by a nurse) stated: - Location: marked with an "X" on sacral area; - Type of Wound: Unstageable; - Presence of Pain: not applicable; - Appearance: necrotic (eschar) 100%; - Length: 13.7 cm; - Width: 16 cm; - Depth: 1.5 cm; - Undermining: at 12 o'clock and 2 o'clock; - Drainage: Purulent moderate;	F 710	treatment order for residents with pressure ulcers. The monitoring will be done daily until the facility consistently reaches 100% success over three consecutive evaluations. Then, the monitoring will be done three times a week until the facility consistently reaches 100% success over three consecutive evaluations. Then, the monitoring will be done once a week until the facility reaches 100% success over three consecutive evaluations. Finally, one more audit will be done a month later. If the center reaches 100% compliance, the QAPI Committee will conclude that the center has successfully addressed the issue.		

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F 710	<p>Continued From page 26</p> <ul style="list-style-type: none"> - Surrounding Tissue: macerated, inflamed/indurated; - Wound Edges: macerated; - Odor: yes. <p>4/18/18 at 10:30 AM - A handwritten physician's order by E22 (NP) stated to clean the sacral wound with Vashe, apply Flagyl powder and Santyl twice a day and PRN.</p> <p>4/18/18 at 1:02 PM - A progress note, written by E22 (NP), stated that R19 was seen and examined due to sepsis. The progress note stated, "...Rash yes, Abrasions yes...Skin Abnormality: assessed, warm: yes, dry: yes...". Despite the change in treatment to R19's sacrum, the clinical record lacked evidence that E22 examined R19's unstageable sacral pressure ulcer and considered that it could be the source of R19's sepsis.</p> <p>4/19/18 at 9:30 AM - A written order by E22 (NP) stated to continue with Santyl twice a day to the sacral wound and discontinue the Flagyl powder.</p> <p>4/19/18 at 11:20 AM - A progress note, written by E22 (NP), stated that R19 was seen and examined for sepsis. Under review of systems, E22 stated that R19 had a PU, but did not identify the location. Despite documentation of a PU and an order to change R19's sacral wound treatment, there was no evidence that R19's unstageable sacral pressure ulcer was examined by E22.</p> <p>4/20/18 at 4:21 PM - A progress note, written by E22 (NP), stated that R19 was seen for sepsis. Despite R19 being seen, the clinical record lacked evidence that R19's unstageable sacral pressure ulcer was examined by E22.</p>	F 710			

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F 710	<p>Continued From page 27</p> <p>4/21/18 at 1:51 PM - A written order by E22 (NP) stated to change R19's sacral pressure ulcer treatment to cleanse with acetic acid, apply Santyl and then Calcium Alginate daily and PRN. The facility failed to identify that R19 now had 2 wound treatments ordered for his sacrum (4/19/18 and 4/21/18). The facility continued wound treatment with the 4/19/18 physician's order.</p> <p>4/21/18 (untimed) - A progress note, written by E22 (NP), stated that R19 was seen and examined. Despite R19 being seen and examined and his sacral pressure ulcer treatment being changed, there was no evidence that R19's unstageable sacral pressure ulcer was examined by E22.</p> <p>4/23/18 at 5:23 PM - The hospital record stated, "...Physical Exam...Skin: 14 cm x 14 cm unstageable sacral decubitus ulcer (same as PU) with exposed bone soiled with stool (sic) patient is incontinent of stool...Per the family, they have been told that he had a relatively small ulcer that was being treated with IV antibiotics at the long-term care facility. However, today he was not speaking to them which was worsening compared to his declining interactions over the last week. Family asked to see the ulcer and it was significantly worse (sic) they would like to believe, at which point they requested that he come here for further evaluation...Patient has extensive ulceration over his lower back with obvious sacral exposure...".</p> <p>4/24/18 at 8:04 AM - A hospital consult by C1 (Plastic Surgeon) stated, "...Wound assessment:...sacrum; size: 9cm x 5cm x 1.2cm; description: Stage IV (4) ulcer of the sacrum with extensive necrotic tissue and sloughing. No</p>	F 710		

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F 710	<p>Continued From page 28</p> <p>tenderness to palpation, mild erythema along borders, no edema or warmth. Kerlix and Mepilex dressing is soaked with exudate and purulence. Edges macerated and undermined. Malodorous...Plan: Continue antibiotic treatment...Will likely need debridement...".</p> <p>4/25/18 - The hospital records stated that R19's Stage IV (4) sacral wound was debrided.</p> <p>1/16/19 at 10:43 AM - During an interview, E4 (Physician) stated that she was told about R19's sacral wound on Friday night, 4/20/18. E4 stated that E22 (NP) did not look at the wound. When asked if she saw R19 during the time he was being treated for sepsis (4/18/18 - 4/23/18), E4 stated that she could not remember if she saw the resident. E4 stated that R19's "medical care was driven by the (managed care partner that E22 worked for), not me".</p> <p>1/16/19 at 6:30 PM - Findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) during the Exit Conference.</p> <p>1/23/19 - Review of additional documentation provided by the facility revealed a text message sent 4/18/18 (untimed) from E22 (NP) to E4 (physician), which stated, "...Meanwhile we noticed his sacral wound looks worse and unstageable but no indication of infection or purulent discharge". This description contradicts the facility's wound assessment by a staff nurse on 4/18/18 which stated R19's sacrum was 100% necrotic, had moderate purulent drainage and an odor.</p> <p>The facility failed to ensure that R19's medical care was supervised by a physician or designee when R19's sacral PU worsened from 3/14/18 to</p>	F 710			

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F 710	Continued From page 29 4/23/18 during which time R19's sacral treatment orders were changed 5 times. R19's sacral pressure ulcer became infected and unstageable requiring debridement in the hospital. The facility lacked evidence that R19's sacral pressure ulcer was examined by the physician and/or the physician's designee.	F 710			
F 755 SS=E	Pharmacy Srvc/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs	F 755			3/6/19

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F 755	Continued From page 30 is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. For one (R66) of three (3) residents observed during the medication pass observation, the facility failed to have anti nausea medication (Promethazine) available. Additionally, review of one (1) of three (3) medication storage rooms and one (1) of three (3) medication carts revealed the presence of expired medications and/or biologicals. Findings include: 1. On 1/11/19 at 9:15 AM, E16 (RN) was observed pouring R66's morning medications. E16 stated that she would also be pouring a dose of Promethazine at R66's request. While preparing the medications, E16 discovered that there was no supply of Promethazine for R66. E16 checked the facility's back up medication supply, however, Promethazine was not one of the medications stocked. Although E16 was able to obtain a one time order for another anti nausea medication that was available, the facility failed to ensure that the Promethazine was available to meet R66's needs. 2. On 1/11/19 at 11:32 AM, the second floor medication storage room was observed along with E15 (Staff Educator/Infection Control Nurse). Observation of the medication refrigerator revealed two (2) opened tuberculin PPD multidose vials. One vial noted it was opened on 8/15/18, the other on 9/27/18. Instructions on the vial labels stated that it should be discarded 30	F 755	R66's PRN Promethazine is in the med cart and is available. The expired two opened Tuberculine PPD multi-dose vials were discarded on 1/11/19. On 1/11/19 R25's expired Lantus insulin was discarded. R32 two blister packs of expired Vitamin D3 were discarded on 1/11/19. Residents receiving PRN Promethazine have the potential of being affected by this deficient practice. Residents receiving Tuberculine PPD, Lantus Insulin and Vitamin D3 have the potential of being affected by this deficient practice. An audit was conducted on January 11 and February 19, 2019 to ensure that all med carts and refrigerators did not contain any expired medications. The root cause of this deficient practice is that the PRN Promethazine was not reordered timely by licensed nursing staff. Licensed nursing staff failed to identify and discard expired medications. The NPE will educate the licensed nursing staff on the need to timely reorder PRN Promethazine and the need to discard expired medications. Education will include the process for acquiring missing medications. Missing medications are to be obtained from the facility's emergency medication kit; missing medication will be delivered by the pharmacy on the next delivery or sooner.		

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F 755	Continued From page 31 days after opening. 3. On 1/11/19 at approximately 11:58 AM, a second floor medication cart was observed with E15 (Staff Educator/Infection Control Nurse). Random observation revealed a vial of Lantus insulin, labeled for R25, that was noted as opened on 11/24/18 and expired on 12/20/18. E15 confirmed the insulin was expired and should have been discarded. 4. On 1/11/19 at approximately 12:05 PM, a second floor medication cart was observed with E15 (Staff Educator/Infection Control Nurse). Random observation revealed 2 blister packs of Vitamin D3 (dietary supplement) 50,000 Units, labeled for R32, had both expired in 11/2016. E15 confirmed both blister packs were expired and should have been discarded. All the above noted findings were reviewed with E2 (DON) on 1/11/19 at approximately 2:40 PM.	F 755	The DON and/or designee will monitor residents receiving PRN Promethazine to determine that the medication is available and that the medication carts and medication room refrigerators do not contain expired medications. Also, the eMARS will be reviewed to identify medications documented as unavailable. This monitoring will be done daily until the facility consistently reaches 100% success over three consecutive evaluations. Then, the monitoring will be done three times a week until the facility consistently reaches 100% success over three consecutive evaluations. Then, the monitoring will be done once a week until the facility reaches 100% success over three consecutive evaluations. Finally, one more audit will be done a month later. If the center reaches 100% compliance, the QAPI Committee will conclude that the center has successfully addressed the issue.		
F 756 SS=D	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	F 756		3/6/19	

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F 756	<p>Continued From page 32</p> <p>drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.</p> <p>(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.</p> <p>(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.</p> <p>§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 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:</p> <p>Based on interview and review of the clinical record and a facility clinical resource as indicated, it was determined that for one (R19) out of 6 sampled residents, the facility's pharmacist failed to identify an irregularity with respect to R19's drug regimen during the monthly review on 4/20/18. Findings include:</p> <p>Review of the facility's Pharmacy Service and Procedure Manual, dated 2017, stated the following: "...Table of Contents...8. Medications which Require Lab Monitoring...This resource provides suggested laboratory monitoring parameters for commonly used medications.</p>	F 756	<p>R19 is no longer receiving Vancomycin.</p> <p>Residents receiving Vancomycin have the potential to be affected by this deficient practice.</p> <p>The root cause of this deficient practice is that the facility pharmacist failed to identify the absence of monitoring Vancomycin trough.</p> <p>The DON and/or designee will educate the pharmacist on the need to monitor labs on residents receiving Vancomycin</p>		

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F 756	Continued From page 33 Appropriate laboratory monitoring of medications requires consideration of many factors including concomitant disease(s) and medication(s), wishes of the resident and family, and current standards of practice. Clinical conditions may require increased monitoring...Vancomycin: ...Serum trough concentration 30 minutes prior to 4th dose, then weekly once stable...". Review of R19's clinical record revealed: 4/19/18 at 12:45 PM - A physician's order for R19 stated to give Vancomycin intravenously every 12 hours for 3 days for sepsis. 4/20/18 (untimed) - A drug regimen review was completed for R19 by the facility's pharmacist. No issues were noted during the review. The facility's pharmacist failed to identify the absence of monitoring R19's Vancomycin trough. 1/15/19 at 3:56 PM - Findings were reviewed with E1 (NHA) and E2 (DON). The facility's pharmacist failed to identify the absence of monitoring R19's Vancomycin trough.	F 756	according to the facility's pharmacy service and procedure manual. The DON and/or designee will monitor residents on Vancomycin to evaluate whether Vancomycin troughs are ordered per policy. This monitoring will be done daily until the facility consistently reaches 100% success over three consecutive evaluations. Then, the monitoring will be done three times a week until the facility consistently reaches 100% success over three consecutive evaluations. Then, the monitoring will be done once a week until the facility reaches 100% success over three consecutive evaluations. Finally, one more audit will be done a month later. If the center reaches 100% compliance, the QAPI Committee will conclude that the center has successfully addressed the issue.		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or	F 757		3/6/19	

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F 757	<p>Continued From page 34</p> <p>§483.45(d)(4) Without adequate indications for its use; or</p> <p>§483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or</p> <p>§483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and review of the clinical record and a facility clinical resource as indicated, it was determined that for one (R19) out of 6 sampled residents, the facility failed to ensure that the resident's drug regimen was adequately monitored. For R19, the facility ordered intravenous Vancomycin, an antibiotic, every 12 hours from 4/19/18 through 4/23/18 with the absence of monitoring the Vancomycin trough. Findings include:</p> <p>Review of the facility's Pharmacy Service and Procedure Manual, dated 2017, stated the following: "...Table of Contents...8. Medications which Require Lab Monitoring...This resource provides suggested laboratory monitoring parameters for commonly used medications. Appropriate laboratory monitoring of medications requires consideration of many factors including concomitant disease(s) and medication(s), wishes of the resident and family, and current standards of practice. Clinical conditions may require increased monitoring...Vancomycin: ...Serum trough concentration 30 minutes prior to 4th dose, then weekly once stable...".</p> <p>Review of R19's clinical record revealed:</p>	F 757	<p>R19 is no longer receiving Vancomycin.</p> <p>Residents receiving Vancomycin have the potential to be affected by this deficient practice. Residents currently on vancomycin were, and are being reviewed to ensure labs are ordered.</p> <p>The root cause of this deficient practice is that the facility failed to order and identify the absence of monitoring Vancomycin trough.</p> <p>The DON and/or designee will educate the licensed nursing staff on the need to order and monitor labs on residents receiving Vancomycin according to the facility's pharmacy service and procedure manual.</p> <p>The DON and/or designee will monitor residents on Vancomycin to evaluate whether Vancomycin troughs are ordered per policy. This monitoring will be done daily until the facility consistently reaches 100% success over three consecutive evaluations. Then, the monitoring will be done three times a week until the facility</p>		

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F 757	<p>Continued From page 35</p> <p>8/27/11 - R19 was admitted to the facility with a diagnosis of chronic kidney disease.</p> <p>4/19/18 at 11:33 AM - A nutritional assessment stated that R19 had abnormal labs that were suggestive of kidney dysfunction.</p> <p>4/19/18 at 12:45 PM - A physician's order by E22 (NP) stated to administer Vancomycin intravenously every 12 hours for 3 days for sepsis. The start date/time was 4/19/18 at 9 PM.</p> <p>4/19/18 through 4/20/18 - Review of R19's eMAR revealed that R19 received Vancomycin on: - 4/19/18 at 9:11 PM; - 4/20/18 at 9 AM.</p> <p>4/20/18 (untimed) - A progress note by E22 (NP) stated that R19 was started on Vancomycin for sepsis and to monitor. The facility failed to order a Vancomycin trough lab to monitor his medication blood level.</p> <p>4/20/18 through 4/21/18 - Review of R19's eMAR revealed that R19 received Vancomycin on: - 4/20/18 at 9:57 PM; and - 4/21/18 at 9:15 AM and 9:57 PM.</p> <p>4/21/18 at 11:31 PM - A physician's order stated to administer Vancomycin intravenously every 12 hours for sepsis until 4/27/18.</p> <p>4/22/18 through 4/23/18 - Review of R19's eMAR revealed that R19 received Vancomycin on the following dates/times: - 4/22/18 at 9 AM and 9:22 PM; and - 4/23/18 at 10:19 AM.</p> <p>4/23/18 at 1 PM - A physician's order by E22 (NP) stated to send R19 to the ER for evaluation.</p>	F 757	<p>consistently reaches 100% success over three consecutive evaluations. Then, the monitoring will be done once a week until the facility reaches 100% success over three consecutive evaluations. Finally, one more audit will be done a month later. If the center reaches 100% compliance, the QAPI Committee will conclude that the center has successfully addressed the issue.</p>		

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F 757	Continued From page 36 4/23/18 at 6:38 PM - The hospital ER record stated, "...Because patient was previously on vancomycin a vancomycin trough level was obtained that was elevated...". 4/24/18 at 12:29 AM - The hospital record stated, "...in the ER...was going to give...vancomycin but levels were already high...". 4/24/18 at 7:10 AM - The hospital record stated, "Vancomycin Dosing by Pharmacy Initial Dosing Note: - Indication for vancomycin therapy: Sepsis - Target vancomycin trough: 15-20... Based on the patient's current weight, renal function, vancomycin level, and previously stated information the plan is to hold vancomycin therapy until level is <20...". 4/24/18 at 9:46 AM - The hospital nephrology consult stated, "...Assessment/Plan: Acute kidney injury, multifactorial. Contributing factors including intravascular volume depletion, vancomycin nephrotoxicity...infection may be contributing...Hold Vancomycin...Dose medication according to GFR less than 20. 4/24/18 at 10:15 AM - The hospital record stated, "Per Hillside, patient received last dose of vanco...on 4/23/18 at (9 AM)..., level drawn at (7:19 PM), 10 hours later which resulted in 45.2...". 1/16/18 at 10:43 AM - During an interview, E4 (Physician) agreed a Vancomycin trough should have been done. E4 stated that it was her practice to have a Vancomycin trough done before the 3rd dose was administered and after it would have been driven by the result, depending	F 757			

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F 757	Continued From page 37 on what the level was. 1/16/18 at 3:56 PM - Findings were reviewed with E1 (NHA) and E2 (DON). The facility failed to ensure that R19's Vancomycin medication was adequately monitored. R19 received a total of 8 doses of Vancomycin in the facility and did not have a Vancomycin trough level done. On 4/23/18, R19 was sent to the hospital where a Vancomycin trough was completed at 7:19 PM, approximately 7 hours after the last Vancomycin dose was administered. The Vancomycin trough measured 45.2, a level over twice the goal of below 20.	F 757			
F 772 SS=D	Lab Services Not Provided On-Site CFR(s): 483.50(a)(1)(iv) §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (iv) If the facility does not provide laboratory services on site, it must have an agreement to obtain these services from a laboratory that meets the applicable requirements of part 493 of this chapter. This REQUIREMENT is not met as evidenced by: Based on clinical record review and interview, it was determined that for one (R19) out of 6 sampled residents, the facility failed to obtain laboratory services to meet the needs of its residents. For R19, the facility failed to obtain routine and STAT labs during the time he was being treated for sepsis. Findings include: Review of R19's clinical record revealed: 4/18/18 at 10:29 PM - A verbal physician's order by E22 (managed care NP) stated to obtain a	F 772	R19 labs are being obtained as ordered. The Lab Services provider has been changed effective February 1, 2019. Residents with orders for stat labs have the potential to be affected by this deficient practice. An audit was done on 2/13/19 to ensure that residents with stat lab orders were drawn. The root cause of this deficient practice is that the lab failed to provide a lab	3/6/19	

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F 772	<p>Continued From page 38</p> <p>CBC and BMP in the morning of 4/19/18 for possible sepsis.</p> <p>4/19/18 at 9:30 AM - A written physician's order by E22 stated "CBC, BMP in AM on 4/20/18".</p> <p>4/19/18 - Review of R19's clinical record lacked evidence that a CBC and BMP lab was done on 4/19/18. The facility failed to obtain labs on 4/19/18 for R19 during the time he was being treated for sepsis.</p> <p>4/20/18 at 4:21 PM - A progress note written by E22 stated that she would follow-up on labs and adjust treatment as needed.</p> <p>4/20/18 at 4:58 PM - A nurse's note stated that a lab draw, ordered on 4/19/18, was performed this AM for CBC and BMP with no results received. The lab had to be drawn again and E22 was notified. E22 ordered the same labs STAT.</p> <p>4/20/18 at 5:10 PM - A nurse's note stated that the lab was called to draw the labs STAT and the facility received a confirmation number.</p> <p>4/20/18 at 9:02 PM - A nurse's note stated that R19's labs were not drawn yet. The lab company called again and stated, "they don't have anyone to come at this time to draw the lab." E22 was notified that the STAT lab would be drawn in the AM on 4/21/18. The facility failed to obtain STAT labs on 4/20/18 for R19 during the time he was being treated for sepsis.</p> <p>4/20/18 at 10:28 PM - A nurse's note stated, "pt (sic) the NP draw lab in AM since no lab tech is available to draw at this time." The facility failed to obtain STAT labs for R19 during the time he was being treated for sepsis.</p>	F 772	<p>technician to draw R19's blood.</p> <p>The new lab services provider is aware of the facility's expectations of complying with stat orders timely.</p> <p>All stat labs will be monitored by the DON and/or designee to evaluate whether the stat lab has been drawn. This monitoring will be done daily until the facility consistently reaches 100% success over three consecutive evaluations. Then, the monitoring will be done three times a week until the facility consistently reaches 100% success over three consecutive evaluations. Then, the monitoring will be done once a week until the facility reaches 100% success over three consecutive evaluations. Finally, one more audit will be done a month later. If the center reaches 100% compliance, the QAPI will conclude that the center has successfully addressed the issue.</p>		

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F 772	Continued From page 39 4/20/18 at 10:30 PM - A verbal physician's order stated, "STAT CBC, BMP ...for sepsis until 4/21/18 ...". 4/21/18 at 10:10 AM - R19's labs were drawn and the facility received the results. 1/15/18 at 3:56 PM - Finding was discussed with E1 (NHA) and E2 (DON). E1 stated that the facility was in the process of changing lab services. The facility failed to obtain routine and STAT labs for R19 during the time he was being treated for sepsis.	F 772			
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for	F 791		3/6/19	

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F 791	<p>Continued From page 40</p> <p>dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay;</p> <p>§483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and</p> <p>§483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, and record review, it was determined that for one (R53) out of two sampled residents, the facility failed to provide the opportunity for routine dental services. Findings include:</p> <p>11/19/18- R53's Significant Change MDS indicated that she was cognitively intact and had no natural or broken teeth.</p> <p>1/8/19 10:37 AM- During an interview, R53 stated she didn't remember seeing a dentist while at the facility. R53 stated she had a broken tooth, but was not having any pain.</p> <p>1/15/19 11:38 AM- During an interview, E17 (Social Worker), stated that residents were offered routine dental care if they wanted to pay for it. E17 stated that the mobile dental lab would let her know who was due for routine dental care. E17 was unable to produce any documentation that R53 was offered routine dental care while residing in the facility.</p>	F 791	<p>R53 was offered and refused routine dental services on January 21, 2019. R53's MDS has been corrected to reflect resident having a broken tooth.</p> <p>Residents residing at the facility have the potential to be affected by this deficient practice.</p> <p>The root cause of this deficient practice is that documentation in the residents' EMR was not consistent regarding the offering of routine dental services at least annually.</p> <p>An audit of in-house residents' EMR will be performed by the Social Services Director and/or designee to determine that documentation of the annual offering of dental services has been done.</p>		

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F 791	Continued From page 41 The facility failed to provide and/or obtain routine dental services for R53. Findings were reviewed with E1 (NHA) and E2 (DON) on 1/16/18 at 3:00 PM.	F 791	The Social Services Director and/or designee will monitor residents' EMR to make sure that documentation of the annual offering of dental services is present. This monitoring will be done monthly until the facility consistently reaches 100% success over three consecutive evaluations. Then, one more audit will be done a month later. If the center reaches 100% compliance, the QAPI Committee will conclude that the center has successfully addressed the issue.		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and test tray results, it was determined that the facility failed to serve food that was appetizing to taste and at a temperature that was palatable for the second floor residents. Findings include: During the resident council meeting on 1/9/19 at approximately 2:00 PM, it was observed that multiple residents raised concerns regarding the temperature of the food. The test tray on 1/15/19 at approximately 1:31	F 804	No specific residents were identified and potentially all residents are affected. Dietary staff will be educated by the Food Service Director (FSD) on temperature standards. Temperatures will be taken and recorded by the cook on duty to determine that temperatures are correct prior to food leaving the kitchen. Temperatures will also be taken and recorded by Dietary staff at each point of service prior to service beginning. All food	3/6/19	

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F 804	Continued From page 42 PM on the second floor confirmed that the soup temperature was at approximately 101F; the soup was tepid or lukewarm and unpalatable. The finding was confirmed with E19 (Director of Food Service) on 1/8/19 at approximately 3:00 PM. The finding was reviewed with E1 (NHA) and E2 (DON) on 1/16/19 at 6:15 PM during the exit conference.	F 804	items out of the proper temperature zone will be corrected prior to continuation of service. The root cause of this deficient practice is that temperatures were not consistently being taken at each point of service. Tray/temperature assessments will be done by the FSD and/or designee for each meal three times per week for three consecutive months until 100% consistent compliance is achieved. Then, one time per week for each meal as an ongoing standard. The FSD will report temperature findings to the QAPI Committee. If the center reaches 100% compliance, the QAPI Committee will conclude that the center has successfully addressed the issue.		
F 809 SS=E	Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) §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. §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. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents	F 809		3/6/19	

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F 809	<p>Continued From page 43</p> <p>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:</p> <p>Based on interviews and review of facility documentation, it was determined that the facility failed to ensure nourishing snacks were offered to all residents at bedtime daily when dinner and breakfast were scheduled greater than 14 hours apart. Findings include:</p> <p>Review of facility documents indicated the following meal times:</p> <p>Dining Room- Dinner 4:30 PM - Breakfast 7:30 AM- 15 hours between dinner and breakfast Fourth Floor- Dinner 5:00 PM - Breakfast 8:00 AM - 15 hours between dinner and breakfast Third Floor- Dinner 5:20 PM - Breakfast 8:20 AM - 15 hours between dinner and breakfast Second Floor - Dinner 5:40 PM - Breakfast 8:40 AM - 15 hours between dinner and breakfast</p> <p>1/14/19 at 4:19 PM- During an interview on the fourth floor, E6 (CNA) stated that snacks were delivered to the floor after dinner. E6 stated that some snacks had resident's names on them and were given to that resident. E6 stated there were usually some extra snacks for people who asked for them.</p> <p>1/14/19 at 4:23 PM- During an interview on the second floor, E7 (CNA) stated that snacks were delivered to the floor with names on them and were only given to those residents.</p> <p>1/14/19 at 4:28 PM- During an interview on the third floor, E8 (CNA) stated that snacks were delivered to the floor with names on them and</p>	F 809	<p>No specific residents were identified and potentially all residents are affected.</p> <p>The root cause of this deficient practice is that bedtime snacks were not consistently offered to residents at bedtime.</p> <p>The facility will implement a routine bedtime snack system that will offer all residents a snack at bedtime. Two snack containers per floor will be replenished daily and distributed to each nursing unit. Nursing staff will offer these snacks to residents nightly.</p> <p>The NPE will educate nursing staff on the new bedtime snack system.</p> <p>The Administrator and/or designee will audit/monitor the effectiveness of this new system by randomly asking residents if they are receiving their bedtime snacks. This monitoring will be done daily until the facility consistently reaches 100% compliance over three consecutive evaluations. Then, the monitoring will be done three times a week until the facility consistently reaches 100% success over three consecutive evaluations. Then, the monitoring will be done once a week until the facility reaches 100% success over three consecutive evaluations. Finally, one more audit will be done a month later. if the facility reaches 100% compliance, the QAPI Committee will conclude that</p>		

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F 809	Continued From page 44 were given out to those particular residents. E8 stated there were extra snacks available if residents asked for them. The facility failed to ensure that nourishing snacks were offered to all residents at bedtime daily when dinner and breakfast were scheduled greater than 14 hours apart.	F 809	this issue has been successfully addressed.	
F 812 SS=F	Findings were reviewed with E1 (NHA) and E2 (DON) on 1/16/19 at 3:00 PM. Food Procurement, Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure that storage of dry food products and ice, handling of clean food-contact surfaces, and handling of food were done under sanitary conditions to prevent	F 812	No specific resident was identified. The two large bins containing dry food were cleaned as was the bin with breadcrumbs. The scoop inside the thickener bin was removed. E9 was educated regarding the	3/6/19

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F 812	<p>Continued From page 45</p> <p>foodborne illness. Findings include:</p> <p>1a. During the initial tour of the kitchen on 1/8/19 at 9:10 AM with E19 (Director of Food Service), two large bins containing dry food products (breadcrumbs and flour) were observed to be dirty on the outside, with a dusting of the contents within them and other debris visible on the surfaces. The bin with breadcrumbs was also observed with dirt of unknown origin attached to the inside of the container.</p> <p>1b. A medium-sized plastic bin with thickener, stored on the shelf underneath a food preparation countertop, was observed as well during the initial tour on 1/8/19 at 9:15 AM with a scoop inside touching the thickener. Upon seeing the bin, E19 stated the scoop should not have been left inside.</p> <p>1c. Observations made on 1/8/19 from 9:30 AM through 9:50 AM in the kitchen's dish room found E9 (Dietary Aide) working on the clean side of the dishwasher wearing a pair of gloves as he retrieved and put away newly washed dinnerware and kitchenware. In the course of the observation period, E9 was seen touching various surfaces in the kitchen and leaving and returning to the kitchen wearing the same pair of gloves. At 9:50 AM, E9 was observed leaving the dish room and returning, holding a container of dish detergent for the dishwasher and assisting with the installation of the detergent. E9 resumed removing clean dinnerware from the racks and putting them away wearing the same gloves. In an interview on 1/8/19 at 11:00 AM, E19 stated that E9 was new and would benefit from additional training on kitchen activities and food service.</p> <p>1d. During lunch service on the third floor, E9</p>	F 812	<p>proper use of gloves, beard guard, hand hygiene and the use of serving utensils. The ice machine on the second floor was cleaned.</p> <p>Other residents have the potential to be affected by this deficient practice.</p> <p>The root cause of this deficient practice is E9's failure to follow the facility's policies and procedures.</p> <p>The FSD will educate Dietary staff on proper cleanliness of storage bins; proper handling of dishes in the dish room; proper use of gloves, beard guard and hand washing procedure; and proper use of serving utensils.</p> <p>The FSD will monitor the cleanliness of the bins and scoop placement; use of gloves, beard guard and hand washing; proper use of serving utensils and proper handling of dishes in the dish room. This monitoring will be done daily until the facility consistently reaches 100% compliance over three consecutive evaluations. Then the monitoring will be done three times a week until the facility consistently reaches 100% success over three consecutive evaluations. then, the monitoring will be done once a week until the facility reaches 100% success over three consecutive evaluations. Finally, one more audit will be done a month later. If the center reaches 100% compliance, the QAPI Committee will conclude that the center has successfully addressed these issues.</p>		

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F 812	<p>Continued From page 46</p> <p>was observed coming out of an elevator pushing the food cart at 12:32 PM with bare hands and parking it by the nurses' station. Without performing hand hygiene at a minimum, E9 then picked up with his hands a stack of clean dishes and placed the dishes on top of the food cart. After applying gel sanitizer, E9 put on gloves and began to plate the foods, touching food cart surfaces in the course of food service. E9 was also observed at 12:52 PM picking up corn muffins with his gloved hand to go on resident plates, although serving utensils, including a pair of tongs, were laid out on the countertop of the food cart in front of him.</p> <p>Findings were reviewed with E1 (NHA) and E2 (DON) on 1/8/19 at 4:30 PM.</p> <p>2. During the first lunch observation on the second floor on 1/8/19 at approximately 2:56 PM, it was observed that the second floor nourishment room ice machine was not clean.</p> <p>The finding was confirmed with E19 (Director of Food Service) on 1/8/19 at approximately 3:00 PM.</p> <p>The finding was reviewed with E1 (NHA) and E2 (DON) on 1/16/19 at 6:15 PM during the exit conference.</p> <p>3a. During a lunch observation on the fourth floor on 1/14/19 at 11:52 AM, E9 was observed plating food without a beard guard.</p> <p>3b. During a lunch observation on the fourth floor on 1/14/19 at 11:52 AM, E9 was observed plating food, removing rolls from a bag (while touching the outside of the bag), then returning to plating food, without any glove change.</p> <p>The facility failed to store, distribute and serve</p>	F 812		

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F 812	Continued From page 47 food in accordance with professional standards for food service safety. Findings were reviewed with E1 (NHA) and E2 (DON) on 1/16/19 at 6:15 PM at the exit conference.	F 812			
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse,	F 842		3/6/19	

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F 842	<p>Continued From page 48</p> <p>neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.</p> <p>§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.</p> <p>§483.70(i)(4) Medical records must be retained for-</p> <p>(i) The period of time required by State law; or</p> <p>(ii) Five years from the date of discharge when there is no requirement in State law; or</p> <p>(iii) For a minor, 3 years after a resident reaches legal age under State law.</p> <p>§483.70(i)(5) The medical record must contain-</p> <p>(i) Sufficient information to identify the resident;</p> <p>(ii) A record of the resident's assessments;</p> <p>(iii) The comprehensive plan of care and services provided;</p> <p>(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;</p> <p>(v) Physician's, nurse's, and other licensed professional's progress notes; and</p> <p>(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, it was determined that the facility failed to ensure that medical records were complete and accurately documented for two (R19 and R66) out of 46 sampled residents. Findings include:</p>	F 842	<p>R66 eTAR is now accurate. R19 nutritional assessment now reflects his accurate medical status.</p> <p>Residents with supra pubic catheters/drainage bags have the</p>		

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F 842	<p>Continued From page 49</p> <p>1. Review of R66's clinical record revealed:</p> <p>11/9/18- R66 was admitted to the facility post hospitalization for short term rehabilitation.</p> <p>11/24/18- R66 had a physician's order to change bedside urinary drainage bag monthly, when occluded or when his urinary catheter was changed, and as needed every day shift every month starting on the 24th for 28 days.</p> <p>11/24/18- 12/3/18- The eTAR was signed by nurses on 11/24/18 through 12/3/18 on day shift every day that R66's urinary bag was changed. On 11/24/18, 11/27/18, 11/28/18, 11/29/18, and 11/30/18 the code NN (nurses notes- same as progress notes) was added to the nurses initials on the eTAR.</p> <p>11/24/18- 12/3/18- Nursing progress notes stated that R66's urinary catheter bag was changed on 11/24/18 and 11/27/18. The other dates either had no documentation about the catheter bag or stated the drainage bag was intact. It was unclear whether the urinary bag was initialed as being checked or whether it was actually changed on 11/25/18, 11/26/18, 11/27/18, 11/28/18, 11/29/18, 11/30/18, 12/1/18, 12/2/18, and 12/3/18.</p> <p>12/4/18- The physician order for changing R66's urinary drainage bag, dated 11/24/18, was discontinued.</p> <p>12/5/18- R66 had a physician's order to change bedside urinary drainage bag monthly, when occluded or when his urinary catheter was changed and as needed every night shift every month starting on the 24th for 28 days.</p> <p>12/6/18- R66's ETAR was signed as done on an</p>	F 842	<p>potential to be affected. Residents having had nutritional assessments completed have the potential to be affected.</p> <p>The root cause of this deficient practice is the incorrect order entry for R66 supra pubic catheter/drainage bag; and copying and pasting information for R19 onto the nutritional assessment.</p> <p>The ADON and/or designee will educate the licensed nursing staff on order entry accuracy for supra pubic catheter/drainage bag. The HSG Director of Clinical Operations and/or designee will educate facility dietitians on documenting the accurate medical status on the nutritional assessment.</p> <p>An audit of residents with supra pubic catheters/drainage bags will be performed by the ADON and/or designee to determine the accurate entry of the physician order. Nutritional assessments of current residents will be audited by the regional dietitian and/or designee to determine accurately documented medical status.</p> <p>The physician order entry of residents with supra pubic catheters/drainage bags will be monitored by the ADON and/or designee. This monitoring will be done daily until the facility consistently reaches 100% success over three consecutive evaluations. Then, the monitoring will be done three times a week until the facility consistently reaches 100% success over three consecutive evaluations. Then the monitoring will be done once a week until</p>		

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NAME OF PROVIDER OR SUPPLIER HILLSIDE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 810 SOUTH BROOM STREET WILMINGTON, DE 19805		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 842	<p>Continued From page 50</p> <p>as needed basis and the urinary catheter was also changed.</p> <p>12/24/18- 1/3/19- R66's eTAR was signed by night shift on 12/24/18, 12/25/18, 12/26/18, 12/28/18, 12/29/18, 12/30/18, 12/31/18 and 1/1/19 as done. 12/30/18 listed NN, however, there was no documentation for this date, as well as the others listed whether the urinary bag was initialed as being checked or whether it was actually changed. On 11/27/18, the nurses initials included the code R for refused by R66.</p> <p>1/3/19- The physician order, dated 12/5/18, was discontinued. A new physician order was written to change R66's bedside urinary drainage bag monthly, when occluded or when his urinary catheter was changed and as needed every night shift every month starting on the 24th for one (1) day (instead of 28 days as the previous orders stated).</p> <p>1/3/19- 1/16/19- R66's ETAR had the dates crossed out except for the 24th for the urinary drainage bag to be changed. If the urinary bag had to be changed on an as needed basis, a nurse would be able to initial the appropriate date(s). There were no dates signed after the order was rewritten on 1/3/19 through the review date of 1/16/19.</p> <p>1/15/19 2:33 PM- E2 (DON) and E3 (ADON) were interviewed. They reviewed the physician orders for R66's urinary drainage bag changes and agreed they were confusing. E2 and E3 also agreed there was a risk of contamination each time the urinary catheter/bag system was opened and stated they would look into this.</p> <p>1/16/19 3:44 PM- E2 and E3 were interviewed.</p>	F 842	<p>the facility reaches 100% success over three consecutive evaluations. Finally, one more audit will be done a month later.</p> <p>A sample of 10 nutritional assessments per week will be reviewed by the center Dietitian for accuracy of diagnoses listed. This review will continue each week until 100% accuracy is achieved for three consecutive weeks.</p> <p>If the center reaches 100% compliance, the QAPI Committee will conclude that the center has successfully addressed these issues.</p>		

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F 842	<p>Continued From page 51</p> <p>Findings were confirmed that it was often unclear in November and December 2018 whether R66's urinary bag was changed or not. E3 stated the problem was corrected by the facility in January 2019 (1/3/19).</p> <p>The facility failed to have complete and accurate documentation in the November and December 2018 eTAR's for R66 regarding the changing of the residents urinary catheter drainage bag. The bag was supposed to be changed monthly or prn when leaking or occluded and it was signed off numerous times. It was unknown for many of the entries whether the drainage bag was incorrectly signed when it was just checked or if the bag was actually changed, as it was often unclear or not addressed at all in the nursing progress notes.</p> <p>2. Review of R19's clinical record revealed:</p> <p>4/1/18 at 1:11 PM - A nutritional assessment stated that R19 had a diagnosis of Congestive Heart Failure (CHF) and that he had a left above the knee amputation (AKA) with a prosthetic leg in place.</p> <p>4/19/18 at 11:33 AM - A second nutritional assessment was completed due to a change in condition with R19. This assessment stated again that he had a diagnosis of CHF and a left AKA with a prosthetic leg in place.</p> <p>Review of R19's clinical record lacked evidence of having a CHF diagnosis. Additionally, R19 never had his left leg amputated.</p> <p>1/15/19 at 3:56 PM - Findings were reviewed with</p>	F 842			

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F 842	Continued From page 52	F 842			
F 880 SS=E	<p>E1 (NHA) and E2 (DON). The facility failed to ensure that 2 of R19's nutritional assessments accurately documented R19's medical status.</p> <p>Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)</p> <p>§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.</p> <p>§483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:</p> <p>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions</p>	F 880		3/6/19	

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F 880	<p>Continued From page 53</p> <p>to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record review, interview and review of facility policy, it was determined that the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Observations of the cleaning/disinfection of glucometers (used to test</p>	F 880	<p>No individual resident was cited for the facility's failure to disinfect glucometers according to facility policy. E10 and licensed nursing staff were educated by the NPE on the facility's policy for disinfecting glucometers. E23 and nursing staff were educated by the NPE regarding the facility's failure to ensure infection control procedures with respect</p>		

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F 880	<p>Continued From page 54</p> <p>blood sugar levels) revealed that one staff nurse (E10/LPN) out of five (5) sampled failed to follow manufacturer specifications for disinfection of glucometers between resident uses. Observations also revealed that two (E12/LPN and E13/RN) out of five(5) staff sampled failed to disinfect glucometers according to facility policy. For R80, the facility failed to ensure infection control procedures with respect to contact precautions were followed by E23 (CNA). Findings include:</p> <p>The facility's policy, revision date 5/15/17, stated, "...blood glucose meters will be disinfected before and after patient use...".</p> <p>Medline Industries "Micro-Kill Bleach," germicidal bleach wipes, instructions stated, "...4. Apply pre-saturated towelette and wipe desired surface to be disinfected. 5. A 30 second contact time is required to kill all of the bacteria and viruses on the label except a 1 minute contact time is required to kill...and a 3 minute contact time is required to kill...6. Allow surface to air dry and discard used wipe...".</p> <p>1. E10 (LPN) was observed performing a blood sugar fingerstick on R10 on 1/10/19 at 8:45 AM. E10 removed the glucometer from the medication cart and wiped it with a Micro-Kill Bleach wipe. Immediately after wiping with the bleach wipe, E10 dried the glucometer with a tissue instead of allowing it to air dry according to manufacturer instructions. E10 stated that she wipes the glucometer off because the wipes are very saturated, and at times, the liquid gets into the meter.</p> <p>After completing the fingerstick, E10 wiped the glucometer with a bleach wipe, again drying it</p>	F 880	<p>to contact precautions for R80.</p> <p>Residents requiring the use of the glucometer are affected by this deficient practice. Residents requiring contact precautions are affected by this deficient practice.</p> <p>The root cause of these deficient practices is that nursing staff did not disinfect the glucometer between resident uses according to facility policy and E23 failed to follow infection control procedures with respect to contact precautions.</p> <p>The NPE will educate nursing staff on the facility's policy for disinfecting glucometers and proper contact precautions according to the facility's infection control procedures.</p> <p>The NPE and/or designee will randomly monitor licensed nursing staff to determine whether facility policy is being followed for disinfecting glucometers between resident use. The NPE will also monitor residents on contact precautions to determine whether infection control procedures are being followed. This monitoring will be done daily until the facility consistently reaches 100% success over three consecutive evaluations. Then, the monitoring will be done three times a week until the facility consistently reaches 100% success over three consecutive evaluations. Then, the monitoring will be done once a week until the facility reaches 100% success over three consecutive evaluations. Finally,</p>		

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F 880	<p>Continued From page 55</p> <p>with a tissue. The Micro-Kill Bleach manufacturer instructions were reviewed with E10 immediately after the observation.</p> <p>2. On 1/10/19 at 11:30 AM, E12 (LPN) was observed performing a blood glucose fingerstick on R443. E12 removed the glucometer from the medication cart and proceeded to complete the fingerstick. E12 did not disinfect the glucometer prior to use as per facility policy.</p> <p>After completion of the fingerstick, E12 disinfected the glucometer with a Micro-Kill bleach wipe and allowed it to air dry.</p> <p>3. On 1/10/19 at 12:07 PM, E13 (RN) was observed performing a blood sugar fingerstick on R344. E13 removed the glucometer from the medication cart and proceeded to complete the fingerstick. E13 did not disinfect the meter prior to use according to facility policy.</p> <p>After completion of the fingerstick, E13 used "Cavi Wipes," a germicidal wipe, to disinfect the meter and allowed it to air dry.</p> <p>All of the above findings were reviewed with E2 (DON) on 1/11/19 at approximately 11:10 AM.</p> <p>2. An observation on 1/8/19 at 1:18 PM revealed that E23 (CNA) exited R80's room that was under contact precautions. E23 was wearing his personal protective equipment (gown and gloves) and removed the PPE in the hallway. E23 did not wash his hands until another staff member observed him and told him to wash his hands.</p> <p>1/18/19 at 1:38 PM - Finding was confirmed with E1 (NHA) and E2 (DON). The facility failed to ensure infection control procedures with respect</p>	F 880	<p>one more audit will be done a month later. If the center reaches 100% compliance, the QAPI Committee will conclude that the center has successfully addressed the issue.</p>		

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F 880	Continued From page 56 to contact precautions were followed by E23.	F 880		



DELAWARE HEALTH AND SOCIAL SERVICES

Division of Long Term Care
Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Hillside Center

DATE SURVEY COMPLETED: January 16, 2019

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
3201 3201.1.0 3201.1.2	<p>The State Report incorporates by reference and also cites the findings specified in the Federal Report.</p> <p>An unannounced annual/complaint survey was conducted at this facility from 1/8/19 to 1/16/19. The facility census the first day of the survey was 97. During this period, an Emergency Preparedness survey was also conducted by the State of Delaware Division of Health Care Quality, Office of Long Term Care Residents Protection in accordance with 42 CFR 483.73.</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 January 16, 2019: F678, F686, F688, F710, F755, F756, F757, F772, F791, F804, F809, F812, F841, F842, and F880.</p>	<p>PLEASE CROSS REFER TO POC ON FORM CMS 2567-L.</p>	<p>3-6-19</p>

Provider's Signature

Title

MHA

Date

2-27-19



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<p>3201.6.0</p> <p>6.9.2</p> <p>6.9.2.4</p>	<p>Services to Residents</p> <p>Specific Requirements for Tuberculosis</p> <p>Minimum requirements for pre-employment tuberculosis...shall comply with the recommendations of the Center for Disease Control (CDC) for the appropriate risk category.</p> <p>This requirement was not met as evidenced by:</p> <p>Based on review of employee tuberculosis (TB) screening records, review of policies and interview, it was determined that the facility failed to ensure that 2 out of 10 sampled personnel had baseline 2 step PPD's administered in accordance with CDC guidelines. Findings include:</p> <p>Review of https://www.cdc.gov/tb/topic/testing/healthcareworkers.htm guideline, last reviewed on 4/15/16, stated, for new hires, if results from the first Mantoux tuberculin skin test (TST) are negative, "Retest in 1-3 weeks after first TST result is read."</p> <p>Review of the facility Tuberculosis Screening policy, dated 10/15/2000 and last revised on 8/27/18, stated, "Process... 2. Administration of the Mantoux Test for employees will be conducted in accordance with state regulations."</p> <p>Review of the Employee Tuberculosis (Mantoux) Screening revealed the following:</p>	<p>E20 AND E21 - E20'S DATE OF READING WAS RECORDED INCORRECTLY.</p> <p>New hires will be tracked for compliance on the PPD log to make sure that the PPD is administered according to policy.</p> <p>The log will be reviewed monthly at QAPI committee meeting to ensure compliance.</p>	<p>3-6-19</p>
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Provider's Signature *Ruth A. Syro* Title NHA Date 2-27-19



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	<p>1. E20 (CNA) was hired on 3/21/18. E20 had the first TST or PPD (Purified Protein Derivative) on 2/27/18 and the second on 4/19/18, more than 7 weeks after the first PPD.</p> <p>2. E21 (LPN) was hired on 2/6/18. E21 had the first PPD on 2/6/18 and the second PPD on 3/6/18, 4 weeks after the first PPD.</p> <p>E15 (Staff Education/Infection Control) was interviewed on 1/14/19 and she confirmed that E20 and E21 were given their second PPD's outside of CDC guidelines. E2 (DON) attended while the findings were reviewed.</p> <p>The facility failed to administer 2 step PPD's for 2 staff members in accordance with CDC guidelines of administering the second step PPD 1-3 weeks after the first PPD.</p>		

Provider's Signature Ruth A. [Signature] Title NHA Date 2-27-19



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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/complaint survey was conducted at this facility from 1/8/19 to 1/16/19. The facility census the first day of the survey was 97. During this period, an Emergency Preparedness survey was also conducted by the State of Delaware Division of Health Care Quality, Office of Long Term Care Residents Protection in accordance with 42 CFR 483.73.</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 January 16, 2019: F678, F686, F688, F710, F755, F756, F757, F772, F791, F804, F809, F812, F841, F842, and F880.</p>		

Provider's Signature _____ Title _____ Date _____



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<p>3201.6.0</p> <p>6.9.2</p> <p>6.9.2.4</p>	<p>Services to Residents</p> <p>Specific Requirements for Tuberculosis</p> <p>Minimum requirements for pre-employment tuberculosis...shall comply with the recommendations of the Center for Disease Control (CDC) for the appropriate risk category.</p> <p>This requirement was not met as evidenced by:</p> <p>Based on review of employee tuberculosis (TB) screening records, review of policies and interview, it was determined that the facility failed to ensure that 2 out of 10 sampled personnel had baseline 2 step PPD's administered in accordance with CDC guidelines. Findings include:</p> <p>Review of https://www.cdc.gov/tb/topic/testing/healthcareworkers.htm guideline, last reviewed on 4/15/16, stated, for new hires, if results from the first Mantoux tuberculin skin test (TST) are negative, "Retest in 1-3 weeks after first TST result is read."</p> <p>Review of the facility Tuberculosis Screening policy, dated 10/15/2000 and last revised on 8/27/18, stated, "Process... 2. Administration of the Mantoux Test for employees will be conducted in accordance with state regulations."</p> <p>Review of the Employee Tuberculosis (Mantoux) Screening revealed the following:</p>		

Provider's Signature _____ Title _____ Date _____



**DELAWARE HEALTH
AND SOCIAL SERVICES**

Division of Long Term Care
Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Hillside Center

DATE SURVEY COMPLETED: January 16, 2019

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	<p>1. E20 (CNA) was hired on 3/21/18. E20 had the first TST or PPD (Purified Protein Derivative) on 2/27/18 and the second on 4/19/18, more than 7 weeks after the first PPD.</p> <p>2. E21 (LPN) was hired on 2/6/18. E21 had the first PPD on 2/6/18 and the second PPD on 3/6/18, 4 weeks after the first PPD.</p> <p>E15 (Staff Education/Infection Control) was interviewed on 1/14/19 and she confirmed that E20 and E21 were given their second PPD's outside of CDC guidelines. E2 (DON) attended while the findings were reviewed.</p> <p>The facility failed to administer 2 step PPD's for 2 staff members in accordance with CDC guidelines of administering the second step PPD 1-3 weeks after the first PPD.</p>		

Provider's Signature _____ Title _____ Date _____