DELAWARE HEALTH AND SOCIAL SERVICES
Division of Health Care Quality
Office of Long Term Care Residents Protection

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

STATE SURVEY REPORT

NAME OF FACILITY: Manor Care Health Services Pike Creek **DATE SURVEY COMPLETED: June 23, 2021**

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced annual and complaint survey was conducted at this facility from June 8, 2021 to June 23, 2021. The facility census on the first day of the survey was 86. The survey sample totaled 38 residents. During this period, an Emergency Preparedness Survey was also conducted by the State of Delaware's Division of Health Care Quality, Office of Long Term Care Residents Protection in accordance with 42 CFR 483.73.		
3201	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.0	**Scope**		
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** This requirement is not met as evidenced by: Cross Refer to the CMS 2567-L survey completed June 23, 2021: F580, F607, F622, F623, F625, F641, F657, F677, F684, F689, F695, F730, F756 and F812.	A. R89 no longer resides in facility B. Audits will be conducted for the past 14 days on all falls to ensure that incident reports were done and completed accurately. If incident report was not completed, an incident report will be immediately completed and investigated.	8/3/2021
9.0	**Records and Reports**		

Provider's Signature _____ Title Administrator Date 7/13/2021
7/21/2021

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9.5	**Incident reports, with adequate documentation, shall be completed for each incident. Adequate documentation shall consist of the name of the resident(s) involved; the date, time and place of the incident; a description of the incident; a list of other parties involved, including witnesses; the nature of any injuries; resident outcome; and follow-up action, including notification of the resident's representative or family, attending physician and licensing or law enforcement authorities, when appropriate.** Based on record review and interview, it was determined that for one (R89) out of five (5) residents sampled for accidents, the facility failed to have three (3) incident reports for R89's falls. Findings include: Review of R89's clinical record revealed: 12/21/2020 at 6:19 AM – A nurse's note stated that R89 was found on the floor in his bedroom. 12/23/2020 at 8:45 AM – A nurse's note stated that R89 was found on the floor next to the bed. 12/27/2020 at 6:19 AM – A nurse's note stated that R89 was found on the floor next to the bed. The facility failed to ensure that incident reports with adequate documentation were completed for R89's three falls. 6/17/2021 at 12:15 PM – Findings were reviewed during the exit conference with E1 (NHA), E2 (DON), E13 (RDO) and E14 (QAC).	C. To prevent recurrence, the Administrator and/or Director of Nursing will educate the Nursing Leadership Team and RN House Supervisors on investigation process. It was determined that the root cause of this deficient practice was the lack of knowledge on how to do a complete investigation. D. Director of Nursing and/or designee will monitor fall incident reports to ensure that they have been fully investigated and completed accurately. Audits will be conducted weekly for 4 consecutive weeks until facility reaches 100% success. Then audits will be done monthly for 2 consecutive months to ensure facility reaches and maintains 100% success. The results of these audits will be reviewed with the Quality Assurance and Assessment Committee (QAA). The Committee will determine the need for additional audits. These audits will be reviewed at the QAA meeting monthly x 2 months.	

Provider's Signature _____ Title Administrator Date 7/13/2021
7/21/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085033	A. BUILDING _____ B. WING _____	C 06/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMEDICA SKILLED NURSING AND REHAB - PIKE CREEK	5651 LIMESTONE ROAD WILMINGTON, DE 19808

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted at this facility beginning June 8, 2021 through June 23, 2021 by the State of Delaware Division of Health Care Quality, Office of Long Term Care Residents Protection in accordance with 42 CFR 483.73. The facility census on the first day of the survey was 86. For the Emergency Preparedness survey, all contracts, operations plan, contact information, and annual emergency drills were up to date. No deficiencies were identified.	E 000		
F 000	INITIAL COMMENTS An unannounced annual and complaint survey was conducted at this facility from June 8, 2021 through June 23, 2021. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census on the first day of the survey was 86. The survey sample totaled 38 residents. Abbreviations / definitions used in this report are as follows: CNA - Certified Nurse's Aide; DON - Director of Nursing; LPN - Licensed Practical Nurse; MDS (Minimum Data Set) - standardized assessment forms used in nursing homes; NHA - Nursing Home Administrator; NP - Nurse Practitioner; RDO - Regional Director of Operations; RN - Registered Nurse; RP - Responsible Party;	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/13/2021

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 SW - Social Worker; QAC - Quality Assurance Consultant; BS - blood sugar (or glucose); Glucagon - medication that increases the level of glucose (sugar) in the blood; MDS- Minimum Data Set - standardized set of assessments completed in nursing homes; QAPI - Quality Assurance Performance and Improvement - multidisciplinary committee that evaluates facility performances; Second degree burn - a mild partial thickness burn affecting the outer layer of skin and part of the second layer; often appear wet, red, are painful and may be blistered and swollen; UTI - urinary tract infection.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the	F 580		8/3/21

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F 580	Continued From page 2 resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specifiec in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that, for one (R93) out of five residents sampled for hospitalization, the facility failed to consult the medical provider to provide the opportunity to change insulin order(s) when the resident's meal intake decreased dramatically. As a result, scheduled insulin was administered resulting in two episodes of	F 580	The statements made on this plan of correction are not an admission to and do not constitute an agreement with alleged deficiencies herein. To remain in compliance with all Federal and State regulations, the facility has taken or will take the actions set forth in this plan of correction. The following plan of	

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F 580	Continued From page 3 hypoglycemia (low blood sugar). Findings include: 1. The facility's procedure entitled Hypoglycemia: Treatment (dated 12/09) identified risk factors for hypoglycemia including "too little food intake." - Treatment for low blood glucose (sugar) of 60 or below was to "follow physician's orders...if not alert...administer [dose] Glucagon (injected medicine to release sugar into the blood when the person cannot swallow). - Steps to be performed for a resident with low blood glucose or sugar (50 or below) with symptoms of severe hypoglycemia (for example loss of consciousness). "...Assess clinical status ...Monitor vital signs every 5-15 minutes until stable. Do not leave patient unattended. Notify physician of clinical problem ...Administer physician's orders for emergency treatment .... [give] Glucagon ...monitor blood glucose (sugar) every 10 minutes until within acceptable range ..if acceptable range is not reached in a reasonable period of time or condition deteriorates, activate EMS (emergency medical system - ambulance) and prepare for emergency transport." Review of R93's clinical record revealed: 6/26/19 - R93 was admitted to the facility with multiple diagnoses, including recurrent urinary tract infections from urinary retention (inability to empty bladder completely) and diabetes (a condition where the body does not make or use insulin made in the body leading to high blood sugar) after being in the hospital with a urinary tract infection (UTI). 6/26/19 - The physicians' orders included several kinds of insulin to be given by injection under the	F 580	correction constitutes the facility's allegation of compliance. All alleged deficiencies have been or will be corrected by the dates indicated. A. R93 no longer resides in facility. No immediate corrective action was taken with R93. B. Utilizing the "Change in Condition" tool audits of residents who are insulin dependent and who consume less than 50% meals with a look back period 7/1/21-7/15/21 will be reviewed. If physician notification is required, nurse will document the notification in the medical record. C. To prevent the deficient practice from reoccurrence; all licensed nursing staff will be educated by the Director of Nursing and/or designee on the "Focus on F-tag 580" and "Change in Condition" nursing process. It was determined that the lack of education regarding the facility's "Change in Condition" was the root cause of the deficient practice. D. Director of Nursing and/or designee will utilize the "Change in Condition" tool to monitor meal intakes for five (5) random residents daily x 3 (three) days with goal of meeting 100% success consecutively, then five residents weekly for four (4) consecutive weeks until facility reaches 100% success. Then monitor for the above monthly, 5 residents until the facility reaches 100% success for two (2)	

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F 580	Continued From page 4 skin to control R93's blood sugar (BS): - Rapid acting insulin (Lispro/Humalog) scheduled before breakfast, lunch and dinner. Hold for BS less than 70. - Rapid acting insulin added to scheduled dose above at mealtime based on blocd sugar 150 or over (sliding scale - higher blood sugar needs more insulin). - Long-acting insulin (Basaglar) at bedtime. 6/26/19 - A care plan was initiated that R93 "is on insulin r/t (related to) diabetes" with the intervention to "educate resident/family/caregiver related to the adherence of medication regime." 7/5/19 - The Admission MDS Assessment included that R93 had severe cognitive impairment (not able to make own decisions) and received insulin daily to control blood sugar. 7/17/19 - A care plan was developed for hypoglycemia with the goal that the "resident will be free from any signs and symptoms of hypoglycemia and will have no complications related to hypoglycemia." Interventions included to monitor compliance with diet; lab tests as ordered; and to monitor vital signs as indicated. 7/30/19 - Physicians' orders included an antibiotic to be given for ten days for a UTI. 8/1/19 - 8/18/19 - Review of CNA documentation of meal intake showed that, out of 54 meals, R93 ate 100% of 49 meals, 75% of two meals (August 6 and 13) and 0% (nothing) for two meals (August 1 and 3). Manufacturer information on Lispro included that the insulin should be injected within 15 minutes	F 580	consecutive months. The results of these audits will be reviewed with the Quality Assurance and Assessment Committee (QAA). The committee will determine the need for additional audits. These results will be reviewed at the QAA meeting monthly x 3 months.	

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F 580	Continued From page 5	F 580		

before a meal or immediately after a meal. This insulin peaks in 30 to 90 minutes after subcutaneous (beneath the layers of skin) injection. Low blood sugar can occur if the right amount of insulin is injected, but less than the usual amount of food is eaten. Hypoglycemia can cause fast heart beat, tiredness, dizziness, shakiness, irritability, slurred speech, mood change, confusion and blurred vision. Untreated hypoglycemia can lead to seizures, loss of consciousness and death. www.lillyinsulinlispro.com (Accessed 6/17/21)

8/19/19 - Review of R93's blood sugar (BS) checks by fingerstick, the electronic Medication Administration Record, meal intake, and nursing Progress Notes showed:

- 7:50 AM: BS 134 (normal fasting [without eating] range 70-99). Scheduled 10 units Lispro insulin given. R93 ate 25% of breakfast. There was no evidence in the clinical record that the physician was informed of R93's poor intake after eating only 25% of breakfast for potential adjustments to scheduled insulin, timing of the insulin injection to after meals and/or the frequency of blood sugar checks.

- 12:15 PM: BS 106. Scheduled 19 units Lispro insulin given before lunch by the same nurse who administered the insulin before breakfast. R93 ate 0% (nothing). There was no evidence in the clinical record that the physician was informed that R93 ate no lunch after receiving 19 units of rapid acting insulin.

- 1:41 PM: A physician note included that R93 had one fall last night with no apparent injury. "Blood sugars are not well controlled on current

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F 580	Continued From page 6 regimen with late afternoon/evening elevations noted." Insulin prior to lunch increased to 23 units to start 8/20/19. This note did not address R93's poor intake from breakfast and lunch. - 2:14 PM: A nursing progress note documented that R93 "was reported to have been up all night ...slept a lot this shift. Appetite fair. Accepting fluids ...". - 5:45 PM: BS 53. A nursing note documented that the Nurse Practitioner (NP) on call was notified of the low blood sugar and ordered for all insulin to be held (not given) until an assessment by the doctor or NP was performed. Glucagon was administered and BS taken in ten minutes was up to 71. - 8:00 PM: BS 186. Basaglar insulin held. R93 "difficult to arouse but briefly opened left eye for nurse." - 9:41 PM: A nursing progress note documented that R93 "refused all meds (medications) on this shift. Had hypoglycemic episode, difficult to arouse. Blood sugar was 53 at 1745 (5:45 PM) and one time Glucagon was given with positive result." 6/16/21 at 11:42 AM - E1 (NHA) confirmed by email there was no evidence that the medical provider was ever informed of the resident's reduced meal intake to provide the opportunity to make adjustments to R93's insulin.	F 580		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and	F 607		8/3/21

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F 607	Continued From page 7 implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on interview, review of facility documentation and review of facility policy, it was determined that for one (E1) out of 14 sampled employees, the facility failed to ensure that they implemented their Abuse Prevention Program Policy. The facility failed to ensure that pre-employment screening of Drug Screening, Adult Abuse Registry, Child Abuse Registry, and fingerprinting was conducted. Findings include: The facility policy entitled, "Abuse, Neglect and Misappropriation of Patient Property Prevention Policy Statement", dated November 2016, stated, "...Center must adopt and operationalize an abuse prevention system that includes screening...". The facility failed to implement their policy and procedure when pre-employment screening was not completed for E1 (NHA). E1's first day as the NHA at the facility was 2/1/21. There was lack of evidence of employee screening including drug testing, checking both adult and child abuse registries, as well as fingerprinting for criminal background check	F 607	A. E1 is still employed by the facility. Pre-employment screening was completed. B. Auditing of all new hires was completed by Human Resources director for the past 30 days (June 1-July 1) If an employee file is known to be incomplete then the Human Resources Director will notify the employee and pre-employment screening will be completed. Employee will be removed from the schedule until all pre-employment screening is completed. C. To prevent the deficient practice from reoccurrence, the Human Resource Director will be educated by the Regional Human Resource Manager/designee on the "Focus on F tag 607" and the facility "Abuse, Neglect and Misappropriate of Patient Property Prevention Policy" statement. The root cause of the deficient practice was noted as the lack of education "F-Tag 607" by the Human Resource Director.	

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F 607	Continued From page 8 before 2/1/2021. 6/21/2021 3:32 PM - An e-mail from E1 was received by the Surveyor which stated, "Since I am a corporate employee and was not hired for the State of Delaware, I did not get what you requested." The facility failed to implement their policy and procedure when pre-employment screening was not completed for E1. 6/23/2021 9:30 AM - Findings were confirmed with E1 (NHA).	F 607	D. Audits will be completed by the Nursing Home Administrator and/or designee to ensure that all required pre-employment paperwork has been completed. All new hires will be audited weekly x4 until facility reaches 100% success and then monthly x 2 until 100% success has been obtained. The results of these audits will be reviewed with the Quality Assurrance and Assessment Committee (QAA). The committee with determine the need for additional audits. These results will be reviewed at the QAA meeting monthly x3 months.	
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility.	F 622		8/3/21

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F 622	Continued From page 9 Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving	F 622		

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PROMEDICA SKILLED NURSING AND REHAB - PIKE CREEK	5651 LIMESTONE ROAD WILMINGTON, DE 19808

(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 622	Continued From page 10 facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on interviews and reviews of clinical records and facility documentation as indicated, it was determined that for three (R3, R55 and R88) out of six sampled residents reviewed for transfer/discharge, the facility failed to meet the transfer and discharge requirements for each resident. Findings include: 1. Review of R3's clinical record revealed: 5/25/21 - A notice of discharge letter was given to R3 and R3's family member. The letter stated that R3 was being discharged for the following	F 622	A. R3 no longer resides in the facility. R88 no longer resides in facility. R55 remains in the facility. B. Audits were completed to ensure the discharge requirements were met for each resident to acute care and facility initiated discharge. The required paperwork includes but not limited to updated care plans. These audits were completed by the Director of Nursing and/or designee. If documentation cannot be located in the medical record;	

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F 622	Continued From page 11 reason, "Your needs cannot be met by the Facility." R3's clinical record lacked evidence of the required physician documentation specifying that the resident's needs cannot be met at the facility, how the facility attempted to meet the resident's needs, and the service(s) that will be available at the receiving facility to meet the resident's needs. 6/16/21 at 2:59 PM - During a combined interview with E2 (DON) and E14 (QAC), findings were reviewed regarding the lack of required physician documentation for the facility-initiated discharge of R3. No further information was provided by the facility. Review of R55's clinical records revealed the following: 1/1/21 - R55 was transferred from the facility to the hospital due to a change in his mental condition. There was lack of evidence that the facility provided the hospital, the receiving provider, R55's comprehensive care plans with goals. 4/14/21 - R55 was transferred from the facility to the hospital due to shortness of breath and decreased oxygen saturation (the amount of oxygen in the blood). There was lack of evidence that the facility provided the hospital, the receiving provider, R55's comprehensive care plans with goals. 6/14/21 at 3:28 PM - An interview with E15 (RN UM) confirmed that the facility lacked evidence	F 622	appropriate documentation will be obtained and sent to the receiving entity as applicable. C. To prevent recurrence of the deficient practice the Director of Nursing/designee will educate the licensed nursing staff on "Focus on F-tag 622" and the "Interdisciplinary Care Transition Checklist. Root cause of the deficient practice was lack of knowledge in regards to "F-Tag 6252" and The Interdisciplinary Transition Checklist. D. Utilizing the "Unexpected hospital Readmission" QAPI tool, the Director of Nursing and/or designee will audit acute care transfers and facility initiated discharges for 3 days with the goal of meeting 100% success consecutively and then weekly for 4 weeks until facility reaches 100% success and then monthly x 2. These audits will include 100% of acute care transfers and facility initiated discharges. The results of these audits will be reviewed with the Quality Assurance and Assessment Committee (QAA). The committee will determine the need for additional audits. These results will be reviewed at the QAA meeting monthly x3 months.	

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F 622	Continued From page 12 that copies of the care plans were sent to the receiving facility when R55 was transferred to the hospital on 1/1/21 and 4/14/21. 06/14/21 at 3:55 PM - In a combined interview, E1 (NHA) and E2 (DON) both confirmed that the facility lacked evidence that care plan goals were sent to the hospital when R55 was transferred on 1/1/21 and 4/14/21. 3. Review of R88's clinical record revealed the following: 9/6/21 - R88 was transferred from the facility to the hospital due to a change in her health condition. There was lack of evidence that the facility provided the hospital, the receiving provider, R88's comprehensive care plans with goals. 6/16/21 10:02 AM - An interview with E5 (SS) confirmed that the facility lacked evidence that a copy of the care plan was sent to the receiving facility. 6/17/21 12:15 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (DON), E13 (RDO) and E14 (QAC).	F 622		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and	F 623		8/3/21

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F 623	Continued From page 13 the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:	F 623		

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F 623	Continued From page 14 (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.	F 623		

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F 623	Continued From page 15 §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews, it was determined that for three (R83, R89 and R91) out of nine residents sampled for hospitalization and/or discharge, the facility failed to provide written notice to the resident and/or the resident's representative(s) of the transfer or discharge to another facility. Findings include: The facility policy on bedholds and transfer/discharge notices, last updated 9/19, indicated the following, "Facility initiated transfer or discharge. When a facility initiated transfer discharge occurs open the [facility initiated transfer or discharge] document, insert [patient] information indicated, print the document, review with patient or patients representative... a copy must be provided to the patient at the the time of transfer/discharge." The undated facility admission information booklet indicated the following on page 4, "...we may terminate this agreement and discharge from the center by notifying you in writing. Where legally required we will notify you at least 30 days prior to your transfer or discharge." 1. Review of R89's clinical record revealed:	F 623	A. R83 no longer resides in facility. R91 no longer resides in facility. R89 no longer resides in the facility. B. Administrator and/or designee will audit all discharges for one month (6/13/21- 7/13/21); excluding AMA and acute transfers to ensure appropriate paperwork was completed. If documentation can not be identified the QAA committee (Ad Hoc) will be notified. C. To prevent recurrence of the deficient practice the Nursing Home Administrator and/or designee will educate the Social Services Department and Department Heads on "focus of F-Tag 623." It was determined the root cause of the deficient practice was lack of knowledge of the facility initiated discharge or transfer letter. D. The Nursing Home Administrator and/or designee will monitor all discharged patients daily x3 days, with goal of meeting 100% success consecutively. and then 50% of weekly discharges for four consecutive weeks	

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F 623	Continued From page 16 4/27/21 10:22 AM - A social service note documented, "...faxed referral to [memory care] unit at [another long term care facility] to see about option of patient transferring there for more appropriate placement due to Dementia diagnosis. Case manger and daughter notified of referral pending." 4/27/21 10:41 AM- A social service note documented, "Ombudsman notified of center looking into [memory care unit] placement at [another long term care facility] for patient as more appropriate placement." 5/11/21 1:52 PM - E3 (SW) documented in a discharge planning/discharge note , "...daughter and Ombudsman notified of transfer to memory care unit at [another nursing facility]. Motor car transport arranged for 10:00 AM pick up. Daughter agreeable to transfer on 5-12-21." 5/11/21- An order was written for R89 to be discharged. 5/12/21- A discharge care plan was updated to include the intervention, R89 "will be discharged to a memory [care] unit... for long term care bed." 5/12/21 1:23 PM - A nursing note documented, "...patient discharged to [another long term care facility] via car service with staff member. All belongings and paperwork sent with them and attempted to call report x (times) 2 with no answer." During an interview on 6/14/21 at 2:48 PM, E3 (SW) confirmed that R89's transfer was facility initiated.	F 623	until facility reaches 100% success. Then monitor monthly, 50% of discharges until the facility reaches 100% success for two consecutive months. Then results of these audits will be reviewed with the Quality Assurance and Assessment Committee (QAA). The committee will determine the need for additional audits. These results will be reviewed at the QAA meeting monthly x3 months.	

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F 623	Continued From page 17 During an interview on 6/15/21 at 9:32 AM, RP1 reported that a written notice was never received by the facility regarding R89's facility initiated transfer. RP1 stated, "They just called and told us R89 had to be transferred, but we didn't get anything in writing or anything." During an interview on 6/15/21 at 9:47 AM, E3 (SW) confirmed that the facility documentation lacked evidence that a written notice was provided to R89 and/or the resident's representative. E3 stated that the facility did not provide written notice because "it was a transfer internally to our sister facility." These findings were reviewed during the exit conference on 6/21/21 at 12:15 PM with E1(NHA), E2 (DON), E13 (RDO) and E14 (QAC). 2. Review of R83's clinical record revealed the following: 5/18/21 R83 was admitted to facility for rehabilitation with a commercial insurance as the primary insurance. 5/19/21 - A care plan for discharge was initiated. 5/25/21- An admission MDS assessment documented that R83 was expected to be discharged to the community, and discharge plans were in place. 6/8/21 12:19 PM - E3 (SW) documented in a discharge planning note, "Wife and patient notified, Insurance [coverage ends] 6-9-21 with a planned discharge home with wife and home health care on 6-10-21. Hospital, bed, commode	F 623		

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F 623	Continued From page 18 and wheelchair and transfer board. Ambulance arranged by stretcher for transport home. Patient and wife agreeable to discharge plans." 6/8/21 - An order was written for R83 to be discharged home with home health care, nursing and rehabilitation care. 6/10/21- R83 was discharged from the facility to the community. 6/11/21 - An Ombudsman discharge notification form documented R83 was discharged on 6/10/21 to the community. During an interview on 6/23/21 at 12:15 PM, E3 (SW) confirmed that R83 did not receive a written discharge notice and stated, "R83 was cut from insurance. It was commercial insurance so no cut (letter) was required. We did the 'My Transition home [facility discharge packet], the Ombudsman was notified and we gave him prescriptions to go home with.'" When asked if a written discharge notice from the facility was provided to R83 or his responsible party, E3 stated, 'No, R83 doesn't get a cut notice.' The insurance gives them everything... There's no 30 day notice or anything like that it because it was a commercial, not a Medicaid, not a state plan." 6/23/21 1:45 PM - During an interview with E1(NHA) it was reported that a written notice was not provided to R83 nor their responsible party because "for Medicaid we would provide the cut letter and in this case we wouldn t because commercial insurance was the primary. We have had our social service director look into it and our regional and they said we don't need it [written notice].	F 623		

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F 623	Continued From page 19 These findings were reviewed during the exit conference on 6/23/21 at 2:00 PM with E1(NHA) and E2 (DON). 3. Review of R91's clinical record revealed: 9/29/21 2:09 PM - A social service note documented that "SW (Social Worker) reviewed DC (discharge) plan process and insurance update. Patient accepted copy of care plan and spoke with daughter about admission program." 9/30/21 8:45 AM - A skilled nursing note documented, "Discharge home with (name of hospice) on October 3rd." 9/30/21 2:14 PM - A skilled nursing note documented, "Patient's family is aware of new orders." 10/1/21 10:25 AM - A skilled nursing note documented, "Spoke with patient's daughter and is aware of transfer." 10/1/21 3:04 PM - A NP (Nurse Practitioner) note stated, "Patient scheduled for discharge on Saturday." 6/16/21 3:13 PM - During an interview, E3 (SW) confirmed that the facility documentation lacked evidence that a written discharge notice was provided to R91 and/or the resident's representative. These findings were reviewed during the exit conference on 6/17/21 at 12:15 PM with E1(NHA), E2 (DON), E13 (RDO) and E14 (QAC).	F 623		

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F 625	Continued From page 20	F 625		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that for one (R91) out of five residents sampled for hospitalization, the facility failed to notify the resident and the resident's representative in writing of the bed-hold notice upon transfer to the hospital. Findings include:	F 625	A. R91 no longer resides in the facility. B. The Director of Nursing and/or designee completed a 30 day (6/13-7/14) comprehensive review to ensure that discharge requirements were met for	8/3/21

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F 625	Continued From page 21 The facility policy on Bedholds and Transfer/Discharge Notices, last updated 9/19, indicated that when a facility initiated transfer discharge occurs, it must be reviewed with patient or patients representative and a copy must be provided to the patient at the time of transfer/discharge. Review of R91's clinical record revealed: 9/29/20 2:09 PM - A social service note documented that "Patient accepted copy of care plan and spoke with daughter about ADM (admission) program." 10/1/20 10:25 AM - A skilled nursing note documented, "...wound to neck is spreading... pain is #10 (severe). NP is aware...Spoke with patient's daughter and is aware of transfer" to the hospital. 6/16/21 3:13 PM - During an interview, E3 (SW) confirmed that the facility documentation lacked evidence and that a bed-hold notice was not provided to R91 and/or the resident's representative when R91 was transferred to the hospital on 10/1/20. These findings were reviewed during the exit conference on 6/17/21 at 12:15 PM with E1 (NHA), E2 (DON), E13 (RDO) and E14 (QAC).	F 625	each resident to acute care. If transfers were completed without the required bed hold policy, a bed hold notice will be provided to the resident and the resident's representative. C. To prevent the deficient practice from recurrence, the Director of Nursing and/or designee will educate licensed nursing staff on "Focus on F-tag 625" and the "Interdisciplinary Care Transition Checklist." The root cause of the deficient process was lack of knowledge of the regulation. D. The Director of Nursing and/or designee will monitor all acute care transfers for documentation of bed hold policy daily for three days, with goal of meeting 100% success consecutively. All acute care transfers will be audited weekly for 4 consecutive weeks until facility reaches 100% success. Then monitor monthly 50% of acute care transfers until the facility reaches 100% success for two consecutive months. The results of these audits will be reviewed with the Quality Assurance and Assessment Committee (QAA). The committee will determine the need for additional audits. These results will be reviewed at the QAA meeting monthly x 3 months.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status.	F 641		8/3/21

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F 641	Continued From page 22 This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews, it was determined that for two(R3 and R41) out of 26 residents reviewed in the investigative sample, the facility failed to accurately reflect each residents' status. Findings include: 1. Review of R3's clinical record revealed: 5/20/21 through 5/25/21 - R3 had an active physician's order for a wanderguard bracelet (helps to prevent the resident from leaving the facility by locking doors/alarming when residents are too close to doorways wired for wanderguard). In addition, R3's May 2021 eMAR revealed that the wanderguard bracelet's function was checked every evening shift by nursing staff. 5/25/21 - R3 received an official notice of discharge letter from the facility. 5/26/21 - The quarterly MDS assessment stated that R3 did not use a wander/elopement alarm and there was no active discharge plan occurring. 6/17/21 at 8:02 AM - Findings were confirmed with E2 (DON). The facility failed to accurately code the 5/26/2021 quarterly MDS assessment. 2. Review of R41's clinical record revealed: 10/12/20 - R41 was admitted to the facility on various medications, including antipsychotics that continued to be given after admission. 10/18/20 - An admission MDS assessment documented that no antipsychotics were received by R41 since admission/entry.	F 641	A. R3 remains in the facility. R3 quarterly MDS was updated to accurately reflect resident's status of wandering/exit seeking. R41 remains in the facility. R41 quarterly was updated to accurately reflect resident's status of medication usage. B. The Director of Nursing and/or designee audited all residents on antipsychotic medications for a 30 day timeframe to ensure MDS accuracy. Utilizing the "Alert Bracelet Coding MDS" tool, the Quality Assurance Consultant (QAC)audited section "N" and "P" for accuracy for a 30 day timeframe. If errors are noted in section "N" and "P", a modification will be made and submitted per RAI requirements. C. To prevent recurrence of the deficient practice, the Regional Case Mix Specialist will educate the MDS staff on "Focus on F-tag 641," and the "RAI-manual; section "N" and "P." It was determined that the root cause of the deficient practice was lack of knowledge of the RAI-manual; section "N" and "P." D. Utilizing the "Psychotropic Medication" and "Alert Bracelet Coding MDS" tool; the NHA and/or designee will monitor completed MDS's of 5 residents daily x 3 days, with goal of meeting 100% success consecutively, and then weekly of 5 residents for 4 consecutive weeks until facility reaches 100% success. Then monitor monthly 5 residents until facility	

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F 641	Continued From page 23 During an interview on 6/11/21 at 1:45 PM, E23 (RN MDS coordinator) confirmed the error on R41's admission MDS assessment. These findings were reviewed during the exit conference on 6/21/21 at 12:15 PM with E1(NHA), E2 (DON), E13 (RDO) and E14 (QAC).	F 641	reaches 100% success for two consecutive months. The results of these audits will be reviewed with the Quality Assurance and Assessment Committee (QAA). The committee will determine the need for additional audits. These results will be reviewed at the QAA meeting monthly x 3 months.	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.	F 657		8/3/21

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F 657	Continued From page 24 This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews, it was determined that for two (R45 and R52) out of two sampled residents for Care Plan Review, the facility failed to ensure that the care plan was prepared by an IDT (Interdisciplinary Team) that included the attending physician or his/her designee, the nurse's aide with responsibility for the resident and a staff member from nutrition/food services staff members. Findings include: 1. The following was reviewed in R45's clinical record: 1/20/21 - The Annual MDS assessment was completed. 2/4/21 - Review of the Care Plan sign in document lacked evidence that R45's attending physician or the designee, the nurse's aide responsible for the resident and a staff member from nutrition/food service participated in the care planning process. 4/21/21 - The Quarterly MDS assessment was completed. 4/21/21 - Review of the Care Plan sign in document lacked evidence that R45's attending physician or the designee, the nurse's aide responsible for the resident and a staff member from nutrition/food service participated in the care planning process. 6/11/21 12:31 PM - An interview with E3 (SS) revealed that IDT Care Conference attendees typically included staff from Activities, Social	F 657	A. R45 still resides in facility. R52 still resides in facility. B. The Nursing Home Administrator and/or designee will audit the last 30 days of Care Plan Meetings to determine documentation of those who participated in the Care Planning Process. Those who participated in the Care Planning will be documented in the Care Plan Focus Summary and/or Progress Notes. The Nursing Home Administrator and/or designee will audit for the previous quarter (April, May, June 2021) that there is evidence of an IDT Care Plan meeting following completion of the MDS assessment. If no documentation of IDT Care Planning then an immediate Care Plan meeting will be scheduled. C. To prevent recurrence of the deficient practice the Nursing Home Administrator and/or designee will educate Social Services on "Focus on F-Tag 657." The root cause of the deficient practice was the lack of knowledge of the regulation of F657. Care conferences will be scheduled based on the ARD review date. Plan of Care will be reviewed and updated by all required participants prior to the care conference. D. The Nursing Home Administrator and/or designee will monitor the documentation of those who participated in the Care Planning process. Audits of 100% of care conferences/care plan	

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F 657	Continued From page 25 Services, and a CNA if available. E3 stated that usually the attendees do not include the attending physician or their designee, the nurse responsible for the resident, or staff from Food/Nutrition Services. E3 confirmed during the 2/4/21 and 4/21/21 Care Plan meetings, that R45's attending physician or their designee, the nurse aide responsible for R45 and a staff member from food/nutrition services did not attend the meetings and there was lack of evidence that these individuals participated in reviewing the Care Plan meetings. E3 further stated there was not a written expectation as to who must attend the IDT Care Plan Meetings or a mechanism utilized to involve these disciplines in the IDT Care Plan Meetings. 2. The following was reviewed in R52's clinical record: 1/27/21 - The Quarterly MDS Assessment was completed. There was lack of evidence of a IDT Care Plan Meeting subsequent to the completion of the assessment on 1/27/21. 4/28/21 - A Quarterly MDS Assessment was completed. 5/14/21 - Review of the Care Plan sign in document lacked evidence that R52's attending physician or designee and staff from nutrition/food service participated in the care planning process. 6/14/21 12:47 PM - An interview with E3 (SS) confirmed that the facility failed to have evidence of an IDT Care Plan Meeting following completion	F 657	documentation will be done daily x3, with the goal of meeting 100% success consecutively, and then audits for 50% of scheduled meetings weekly for 4 consecutive weeks until facility reaches 100% success. Then monitor monthly of 50% of scheduled care plan meetings until the facility reaches 100% success for 2 consecutive months. The results of these audits will be reviewed with the Quality Assurance and Assessment Committee (QAA). The committee will determine the need for additional audits. These results will be reviewed at the QAA meeting monthly x3 months. The Nursing Home Administrator and/or designee will monitor evidence of an IDT Care Plan Meeting was scheduled following completion of the MDS assessment. The audits will be done daily x3, with the goal of meeting 100% success consecutively, and then weekly for 4 consecutive weeks until facility reaches 100% success. Then monitor monthly until the facility reaches 100% success for 2 consecutive months. The results of these audits will be reviewed with the Quality Assurance and Assessment Committee (QAA). The committee will determine the need for additional audits. These results will be reviewed at the QAA meeting monthly x3 months.	

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F 657	Continued From page 26 of the MDS assessment on 1/27/21. Additionally, E3 confirmed that during the 5/14/21 Care Plan meeting, R52's attending physician or designee and a staff member from food/nutrition services did not attend the meeting and there was lack of evidence that these individuals participated in the care planning process. 6/17/21 at 12:15 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (DON), E13 (RDO) and E14 (QAC).	F 657		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and review of related clinical information, it was determined that the facility failed to ensure that a resident who was unable to carry out activities of daily living (ADL) received the necessary services to maintain personal hygiene for one (R52) out of two sampled residents for ADL review. Findings include: Review of R52's clinical record revealed the following: 9/21/20 - R52 was admitted to the facility with left sided weakness due to a stroke affecting her hand. 3/3/21 (most recent revision date) - A care plan for ADL deficit documented that R52 required	F 677	A. R52 remains in facility. On 6/16/2021 R52 was offered and refused nail care. R52's Plan of Care was updated to reflect residents preference. B. Director of Nursing and/or designee will audit dependent residents to ensure appropriate grooming per resident wishes was completed. If nail care is not found satisfactory during this audit, nail care will be offered and follow up documented in progress notes. If resident refused nail care, the plan of care will be updated to reflect the resident preferences. C. To prevent recurrence of this deficient practice the Director of Nursing and/or designee will educate nursing staff on	8/3/21

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F 677	Continued From page 27 assistance of staff with personal hygiene, bathing, dressing, safe transfers, toileting, and set-up for eating. Interventions included assisting with daily hygiene, grooming, dressing, oral care and eating. 4/28/21 - The most recent Quarterly MDS assessment documented that R52 required extensive assistance of staff for personal hygiene needs. 6/9/21 11 AM - An interview with R52 revealed that she was unable to perform her own nail care due to her left hand weakness and she relied on the staff. R52's right hand nails were untrimmed and jagged with encrusted debris underneath the nails. R52 refused to allow the Surveyor to observe the left hand which was covered by the sheet on her bed. R52 stated she does not recall when her nails were last trimmed, but would like for them to be cleaned and trimmed. 6/14/21 10:56 AM - R52's right hand had untrimmed nails with encrusted black debris underneath the nails. 6/14/21 10:59 AM - An interview with E10 (CNA) stated routine nail care, including trimming of nails was performed as needed and was not scheduled on a particular day of the week or shift. 6/14/21 12:15 PM - An interview with E7 (CNA), the assigned CNA to R52 revealed that there was no specific day of the week that nail care was offered. E7 further stated that she was assigned to R52 periodically and E7 does not recall R52 refusing care, including nail care. E7 stated that she did not observe R52's right hand nails today and stated that R52 usually keeps her left hand	F 677	"focus on F-tag 677" and "AM Care" nursing procedure. The root cause of deficient practice was lack of knowledge in regard to AM Care/Dignity observation procedures. D. The Director of Nursing and/or designee will audit 5 residents daily x3 days, with the goal of meeting 100% success consecutively, and then 5 residents weekly for 4 consecutive weeks until facility reaches 100% success. Then monitor 5 residents monthly until the facility reaches 100% success for 2 consecutive months. The results of these audits will be reviewed with the Quality Assurance and Assessment Committee (QAA). The committee will determine the need for additional audits. These results will be reviewed at the QAA meeting monthly x3 months.	

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F 677	Continued From page 28 closed. Subsequent to this interview, E7 stated she asked R52 whether she would like to have her nails trimmed, however, R52 refused. E7 stated to the Surveyor that E7 plans to re-approach R52 later to see if R52 will allow E7 to perform nail care. 6/15/21 11:14 AM - R52 showed the Surveyor her right hand nails that were trimmed and cleaned. R52 stated that she had her left hand nails trimmed as well, but refused to show the Surveyor her left hand. 6/15/21 1:22 PM - An interview with E2 (DON) revealed that nail care was to be provided during scheduled shower days twice a week by the CNA. 6/15/21 3:24 PM - E2 (DON) provided the Surveyor a policy and procedure that nail care was to be provided during daily morning care. The facility failed to provide the necessary nail care to R52, who was unable to perform this ADL. 6/17/2021 at 12:15 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (DON), E13 (RDO) and E14 (QAC).	F 677		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered	F 684		8/3/21

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F 684	Continued From page 29 care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, it was determined that the facility, for one (R45) out of five residents sampled for medication review, the facility failed to follow the physician's order for a medication to treat high blood pressure and other heart conditions. Findings include: The following was reviewed in R45's clinical record: 1/15/19 - R45 was admitted to the facility. 4/4/21 - A Physician's Order was written for a medication to treat R45's high blood pressure and other heart conditions to be given twice a day and hold the medication if the systolic blood pressure (SBP, the top number of a blood pressure reading) was less than 120 and/or the heart rate was less than 60 beats per minute. 4/1/21 through 6/15/21 - Review of the Electronic Medication Administration Record documented on the following dates and times that the facility failed to follow the physician's order to hold the above medication as ordered: - 4/21/21 at 8 AM; R45's heart rate was 59. - 5/2/21 at 12 AM; R45's heart rate was 55. - 6/7/21 at 4 PM; R45's SBP was 115. - 6/12/21 at 4 PM; R45's SBP was 113. 6/16/21 11 AM - Findings were confirmed with E4 (RN UM) that the facility failed to hold the above medication as per the physician's ordered parameters.	F 684	A. R45 still resides in facility. R45 Medication Regiment Review (MRR) was reviewed with the medical provider and the facility process for medication errors was completed on 6/16/2021. B. Director of Nursing and/or designee will complete audits for residents receiving Anti-Hypertensive with parameters for the period of 6/16/2021-7/12/2021 to ensure parameters were followed. If medications are noted to be given outside of parameters, the facility process for medication errors will be completed. C. To prevent reoccurrence of the deficient practice the Director of Nursing and/or designee will educate the licensed nursing staff "focus on F-tag 684" and "Medication and Treatment Administration guidelines." The root cause of deficient practice was lack of education related to Medication Treatment Administration guidelines. D. Director of Nursing and/or designee will monitor 5 residents who are receiving Anti-hypertensive with parameters for 3 days, with the goal of meeting 100% success consecutively, and then 5 residents weekly for 4 consecutive weeks until facility reaches 100% success. Then monitor 5 residents monthly until the facility reaches 100% success for 2 consecutive months. The results of these audits will be reviewed with the Quality	

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F 684	Continued From page 30 6/17/21 at 12:15 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (DON), E13 (RDO) and E14 (QAC).	F 684	Assurance and Assessment Committee (QAA). The committee will determine the need for additional audits. These results will be reviewed at the QAA meeting monthly x3 months.	
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined that the facility failed to ensure that a resident environment was free from accident hazards for one (R6) out of two residents reviewed for accident hazards. R6 sustained a mild burn from spilled coffee that had not been reviewed for temperature before serving. R6 then did not receive an immediate assessment from a nurse when a CNA failed to report that R6 spilled coffee on herself. Findings include: 3/1/21 - A facility Inservice was held to review the "Hot beverage safety" policy that indicated the following: "Dispensing hot beverages consider temperature range of 150-155 degrees Fahrenheit as an approximate guide for hot beverages leaving the kitchen; record the temperature taken on the food tempature log." Review of R6's clinical record revealed:	F 689	Past noncompliance: no plan of correction required.	

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F 689	Continued From page 31 2/17/21 - An MDS assessment documented R6 as cognitively intact and able to eat independently after set up assistance. 4/14/21 untimed - A written statement from E26 (CNA) documented the following "Patient call light went on I went to attend to R6 as I continue to change R6's brief I noticed some redness and blisters on the right side, when I asked R6 stated, she dropped some hot coffee, I asked if R6 had reported it to anyone R6 said no so I notified the nurses as soon as possible." 4/15/21 2:02 AM - A nursing progress note documented, "It was called to my attention this morning at 1:30 AM that this resident has a burn on the right abdomen. I went in and assessed the burn it was red and have some blister spot on it. I offered to place ice and some ointment to the site to ease the dryness but resident refused said I am fine and I asked R6 if she is in any pain R6 said 'No, I am not in any pain.' When I ask the resident why did not let aide know about the accident R6 said 'I don't any one to be in trouble or get fired.' I educated R6 that your safety is more important to us next time when something bad happen please notify the staffs as soon as possible so that you will get treatment. R6 said ok, NP was notify 1: 40 AM and prescribed silvadine cream for the burn to apply it twice a day until it get resolved." 4/15/21 4:14 AM - A nursing progress note documented "...on 4/15/21 11-7 shift at 1:30 [AM], CNA called me to resident room and showed to me a redness and water filled blister around resident right abdomen through her back. It measures 34 cm x (by) 12 cm . Resident states	F 689		

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F 689	Continued From page 32 she dropped a hot coffee on themselves while was trying to drink the coffee. According to resident, she stated they did not tell anybody because they did not want to put the aide into trouble. MD on call and resident [responsible party] made aware. Nurse Practitioner gave new order for cream to apply to the site two times per day until resolve... Currently rest ng with no complaint of pain to the site." 4/15/21 4:45 AM - A nursing progress note documented, "Resident stated the incident happened yesterday 3-11 shift at 6:40 PM during dinner time." 4/15/21 - A complaint report submitted to the state agency by the facility documented R6 received a "burn to patients abdomen and hip secondary to patient spilling coffee on oneself. Carafe temperature was not done prior to leaving kitchen." 4/15/21 untimed - A written statement from E27 (CNA) documented regarding R6's spilling coffee onto herself, "R6 showed me where on right side of stomach and hip and some on the bed. I asked [to change her] and R6 said no, R6 said the shirt was fresh, incontinence care was provided." In response to being asked whether E27 reported to the nurse that R6 spilled coffee on herself, E27 stated "no." 4/15/21 untimed - A written statement from E28 (CNA) documented that E23 served R6 coffee "around 6:00 PM" and that the coffee was obtained from "the carafe on the 2nd floor." 4/15/21 - A care plan for burns to right abdomen/right flank was created for R6.	F 689		

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PROMEDICA SKILLED NURSING AND REHAB - PIKE CREEK	5651 LIMESTONE ROAD WILMINGTON, DE 19808

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F 689	Continued From page 33 4/16/21 untimed - A written statement from E24 (cook) documented, "...as the cook I only take the temperature on the hot beverages on the trays on the tray line." 4/16/21 untimed - A written statement from E25 (dietary aide) documented the following exchange: "Did you provide hot beverages for the second floor? yes. Did you [take the] temperature of all the hot beverages that went out to the units that evening? No I didn't remember to take the temperature." Review of the attendance log for the facility Inservice on hot beverage safety policy revealed E25 was in attendance of that Inservice. During an interview on 6/8/21 at 1:00 PM, R6 confirmed the prior burn from spilling coffee and that an assessment for her burn related injury was not immediately performed. R6 then stated, "I didn't even say anything at first because I didn't want to make a big deal." During an interview on 6/15/21 at 11:45 AM, E27 (CNA) confirmed that R6's spilling of coffee was not immediately reported to a nurse. E27 stated, "The next day I come in they [facility staff] asked me did I tell the nurses I said no. So they warned me not to do that anymore. I forgot to tell the nurse it wasn't my intention. R6 was my resident that very day, R6 call[ed] around 7:00 PM between 7-7:30 PM R6 call[ed] to get changed so when I enter the room I saw R6's clothes wet so I asked what happened and R6 told me she was drinking the coffee and spilled it... R6 had new clothes and would not to take it off. Then around 9:00 PM R6 call[ed] again and still refused to change clothes. I provided the incontinent care	F 689		

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F 689	Continued From page 34	F 689		

and I left. The following morning I was home and they called me and they told me R6 spilled the coffee and I told them all that I saw but R6 refused to take off the clothes, so I didn't know if there was an injury."

During an interview on 6/15/21 at 1:13 PM, E2 (DON) was asked "What prompted the hot beverage safety training on 3/1/21?" E2 responded "We were on a division [internal corporation] call, they had a burn at another facility so we thought we would give a refresher of the policy." E2 then confirmed that the facility did not have a system for logging temperatures of hot beverages in carafes and coffee pots prior to R6's burn incident and stated "that [obtaining/recording temperatures] was in response to the incident [R6's burn]. We had previously not been using the carafes/pots because of COVID. That was our first day returning to using them and E(25) dietary aide, just forgot to temp them."

6/15/21 immediately after interview -E2 (DON) submitted facility documentation that on 4/15/21 the facility identified R6 as the resident impacted by this deficient practice, they assessed and treated R6 for a burn injury and initiated an occupational therapy screen. On 4/15/21 QAPI provided education to department heads on hot beverage safety and additional education was provided to clinical and dietary staff regarding hot beverage safety and a change in condition reporting. A root cause analysis was determined and a follow up report was submitted to the state agency. The facility identified other residents with potential to be affected, thus on 4/16/21 the facility implemented a temperature logging system for hot beverages on trays, as well as carafes and coffee pots. The logging system has

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F 689	Continued From page 35 been used since 4/16/2021 and has had a 100% compliance in regards to hot beverages leaving the kitchen at the proper temperature since implementation. The facility food service director is going to continue utilizing the log and reviewing it daily to ensure continued compliance. The facility had no further incidents related to residents burning themselves from coffee from 4/14/21 to the present. Review of facility documentation indicated there was sufficient evidence to determine that the facility corrected the non-compliance and was in substantial compliance as of 4/20/21. These findings were reviewed during the exit conference on 6/21/21 at 12:15 PM with E1(NHA), E2 (DON), E13 (RDO) and E14 (QAC).	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that for one (R45) out of two sampled residents reviewed for the use of oxygen, the facility failed to change the resident's oxygen tubing weekly. Findings include: 6/9/21 1:48 PM - A random observation of R45's	F 695	A. R45 still resides in facility. Oxygen tubing was immediately changed. B. The Director of Nursing and/or designee audited all residents who had orders for oxygen to ensure that the tubing was labeled accurately with the	8/3/21

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F 695	Continued From page 36 oxygen concentrator tubing lacked evidence of a date. 6/10/21 2:30 PM - A subsequent observation of R45's oxygen concentrator tubing lacked evidence of a date. A joint observation was immediately done with E11 (LPN) who confirmed the lack of date on the tubing. E11 stated the facility's process was to change the tubing weekly during the night shift. 6/17/21 at 12:15 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (DON), E13 (RDO) and E14 (QAC).	F 695	date. If tubing was noted without date/label; tubing will be replaced and labeled appropriately. C. To prevent recurrence, The Director of Nursing and/or designee will educate Licensed nursing staff on "Focus on F-tag 695" and "Oxygen Administration" procedure. The root cause of the deficient practice was lack of knowledge in the changing and labeling of oxygen. Changing and labeling of oxygen tubing will be done weekly and as needed. D. Utilizing the "Oxygen" QAPI tool; the Director of Nursing and/or designee will audit all residents who require oxygen x3 days, with goal of meeting 100% success, then monitor all residents who require oxygen weekly for four consecutive weeks until 100% success. Then monitor 50% of all residents who require oxygen monthly until the facility reaches 100% for 2 months. The results of these audits will be reviewed with the Quality Assurance and Assessment Committee (QAA). The committee will determine the need for additional audits. The results will be reviewed at the QAA monthly x3 months.	
F 730 SS=D	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a perfcrmance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the	F 730		8/3/21

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F 730	Continued From page 37 requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on interview and review of other facility documentation as indicated, it was determined that the facility failed to ensure that performance appraisals were completed at least every 12 months for one (E12) out of five sampled CNAs. Findings include: Review of E12's personnel records revealed: 4/28/03 - The first day of employment at the facility for E12 (CNA). 8/29/19 - The most recent annual performance appraisal was completed for E12. 3/13/21 - The last day that E12 worked at the facility. There was lack of a performance appraisals at least every 12 months for E12 as none was done in 2020. 6/16/21 3:30 PM - An interview with E5 (HRD) confirmed that the facility failed to have evidence of a performance appraisal at least every 12 months for E12 and the last appraisal was completed on 8/29/19. 6/17/21 at 12:15 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (DON), E13 (RDO) and E14 (QAC).	F 730	A. E12 is no longer employed with the company. B. The Human Resources Director and/or designee will audit current nurse aides for completion of Performance Appraisals. These audits will be completed for the time period of January 1, 2021-June 30, 2021. If a nurse aide performance appraisal is noted to be overdue the manager of that nurse aide will be notified and the appraisal will be immediately completed. C. To prevent recurrence of the deficient practice the Nursing Leadership/Management team and Human Resources Director will be educated by the Nursing Home Administrator and/or designee on "focus on F-Tag 730." The root cause of the deficient practice was lack of knowledge for Nursing Leadership/Management and Human Resources of getting appraisals done in a timely fashion of every 12 months. D. The Nursing Home Administrator and/or designee will monitor the performance appraisals for nursing aides. These audits will be done for all Nurse Aides who are due their appraisals for July x4 consecutive weeks until facility reaches 100% success and then monitor all Nurse Aides who are due their appraisals for 2 consecutive months	

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F 730	Continued From page 38	F 730	(August and September). The results of these audits will be reviewed with the Quality Assurance and Assessment Committee (QAAA). The committee will determine the need for additional audits. These results will be reviewed at the QAA monthly x3 months.	
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 drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in	F 756		8/3/21

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F 756	Continued From page 39 the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure for two (R45 and R52) out of five sampled residents for medication review, that the irregularities and recommendations identified by the pharmacist were acted upon. Findings include: 1. The following was reviewed in R45's clinical record: 12/2/20 - The Medication Regimen Review (MRR) Report completed by the Consultant Pharmacist for December 2020 documented a recommendation to discontinue the hold parameters for two medications ordered to treat high blood pressure. The report contained boxes to check "...accept..." or "...decline..." which were blank. 6/16/21 11 AM - An interview with E2 (DON) confirmed that the facility had no evidence that the 12/2/20 MRR Report was provided to R45's attending physician. There was lack of evidence that the above MRR Report was provided to R45's attending physician.	F 756	A. R45 still remains in facility. R52 still remains in facility. R45 was not affected by this practice. R52 was not affected by this practice. B. The Director of Nursing and/or designee will complete an audit of June Medication Regimen Reviews (MRR) completed by the consulting Pharmacist to ensure the recommendations are followed accordingly. If MRR's are noted with recommendations that have not been addressed by the medical provider, they will be readdressed with the medical provider. C. To prevent recurrence of the deficient practice, the Director of Nursing and/or designee will educate Nursing Leadership/Management team on "focus on F-tag 756" and "Clinical FYI number 52" "Medication Regimen Reviews." It was determined the root cause of the deficient practice was lack of knowledge of the regulation of Medication Regimen Reviews. D. The Director of Nursing and/or	

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F 756	Continued From page 40 2. The following was reviewed in R52's clinical record. 6/7/21 - The MRR Report for June 2021 documented a recommendation to periodically reevaluate the risk, the benefit of continued use of two antidepressants and to consider trial dose reduction of one of the medications. The response by the medical practitioner was "...no change at this time...". There was lack of evidence of the rationale by the medical practitioner on this report or in the progress notes. 6/16/21 11 AM - An interview with E2 (DON) confirmed that for R52's 6/7/21 MRR Report recommendation, that the facility was unable to provide evidence of a decision not to change R52's medication regimen at this time. 6/17/21 at 12:15 PM - Findings were reviewed during the exit conference with E1 (NHA), E2, E13 (RDO) and E14 (QAC).	F 756	designee will monitor Medication Regimen Reviews sent by Pharmacy Consultant of five residents x3 days with the goal of meeting 100% success consecutively, and then monitor 5 residents weekly for four consecutive weeks until facility reaches 100% success. Then monitor 5 residents monthly until the facility reaches 100% success for two consecutive months. The results of these audits will be reviewed with the Quality Assurance and Assessment Committee (QAA). The committee will determine the need for additional audits. These results will be reviewed at the QAA meeting monthly x3 months.	
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility	F 812		8/3/21

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F 812	Continued From page 41 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 observations and interviews, it was determined that the facility failed to provide the necessary means to maintain kitchen personal hygiene in accordance with professional standards for food service safety. Findings include: The following was observed on 6/8/21 at approximately 9:30 AM during the initial kitchen tour: The hand sink at the dish washing area was blocked by a floor fan, making the handwashing station inaccessible. E29 (Food Service Director) confirmed the finding and moved the floor fan at approximately 10:00 AM. Finding was reviewed and confirmed with E29 on 6/8/21 at approximately 10:15 AM.	F 812	A. No residents were affected by this deficient practice. The hand sink at the dishwashing area, that was blocked by a floor fan, was immediately fixed. B. All staff/residents have the potential by being affected by this practice. C. The Food Service Director (FSD) and/or designee will educate the dietary staff on the importance of immediately notifying the Maintenance Director and/or designee and place in TELS (Electronic Work Order System) when equipment needs to fixed or serviced. D. Food Service Director and/or designee will monitor hand sinks to make sure that they are in proper working condition. Audits of all hand sinks will be completed x3 days, with the goal of making 100% success consecutively, and then all sinks weekly for four consecutive weeks until facility reached 100% success. Then monitor monthly all sinks until the facility reaches 100% success for two consecutive months. The results of these audits will be reviewed with the Quality	

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F 812	Continued From page 42	F 812	Assurance and Assessment Committee (QAA). The committee will determine the need for additional audits. These results will be reviewed at the QAA meeting monthly x3 months.	