

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

PRINTED: 11/13/2019  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>085037</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>09/20/2019</b>
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NAME OF PROVIDER OR SUPPLIER  <b>ATLANTIC SHORES REHABILITATION &amp; HEALTH CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>231 SOUTH WASHINGTON STREET MILLSBORO, DE 19966</b>
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E 000	Initial Comments  An unannounced annual and complaint survey was conducted at this facility from September 15, 2019 through September 20, 2019. The facility census the first day of the survey was 167. During this period an Emergency Preparedness Survey was also conducted by the State of Delaware's Division of Health Care Quality Long Term Care Residents Protection in accordance with 42 CFR 483.73.	E 000		
F 000	For the Emergency Preparedness survey, no deficiencies were cited.  INITIAL COMMENTS  An unannounced annual and complaint survey was conducted at this facility from September 15, 2019 through September 20, 2019. The deficiencies contained in this report are based on observation, interviews, review of residents' clinical records and other facility documentation as indicated. The facility census the first day of the survey was 167. The survey sample totaled fifty (50).  Abbreviations/Definitions used in this report are as follows: 1:1 supervision - a staff member is assigned to supervise only one resident; usually for safety; ADON - Assistant Director of Nursing; Advanced Directives - a legal document (such as a living will) signed by a competent person to provide guidance for medical and health-care decisions (such as the termination of life support or organ donation) in the event the person becomes incompetent to make such decisions; Assistant NHA (ANHA) - Assistant Nursing Home Administrator;	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  Electronically Signed	TITLE	(X6) DATE  10/19/2019
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	<p>Continued From page 1</p> <p>BIMS - (Brief Interview for Mental Status) - test to measure thinking ability with scores ranging from 00 to 15.</p> <p>13-15: Cognitively intact 08-12: Moderately impaired 00-07: Severe impairment;</p> <p>Care Tracker - point of care documentation for CNA's to record the care they provide to residents;</p> <p>cm (centimeters) - measurement of length, 1 centimeter = 0.39 inches;</p> <p>CNA - Certified Nurse's Aide;</p> <p>CPR - cardiopulmonary resuscitation which is provided to people when their heart beat and/or breathing stops;</p> <p>CRNP - Certified Registered Nurse Practitioner;</p> <p>DMOST - Delaware Medical Orders for Scope of Treatment;</p> <p>Dementia - overall term for diseases and conditions characterized by a decline in memory, language, problem-solving and other thinking skills that affect a person's ability to perform everyday activities;</p> <p>Dementia with behavior disturbances - common behavioral abnormalities with dementia includes symptoms such as depression, anxiety psychosis, agitation, aggression, disinhibition, and sleep disturbances;</p> <p>DNI - Do not intubate;</p> <p>DNR - Do not resuscitate;</p> <p>DON - Director of Nursing;</p> <p>EHR - electronic health record;</p> <p>e.g. - for example;</p> <p>eMAR/EMAR - electronic medication administration record;</p> <p>etc. - and so forth;</p> <p>FM - family member;</p> <p>FSD - Food Service Director;</p> <p>Full code - designation to provide emergent</p>	F 000		
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F 000	Continued From page 2 measures to attempt to resuscitate a patient; h - hour; IJ - immediate jeopardy; LPN - Licensed Practical Nurse; MD - Medical Doctor; mg (milligrams) - unit of weight, 1 mg equals 0.0035 ounce; Minimum Data Set (MDS) - comprehensive clinical assessment of residents; Namaste room - Room where residents with advanced dementia or agitation are provided a peaceful, quiet, welcoming, non-isolating environment throughout the day that allows them dignity; NHA - Nursing Home Administrator; NP - Nurse Practitioner; POA - power of attorney is a written authorization to represent or act on another's behalf in legal matters; PRN - as needed; Pressure ulcer - sore area of skin that develops when the blood supply to it is cut off due to pressure; q - every; QA - Quality Assurance; RD - Registered Dietician; RN - Registered Nurse; RNC - Regional Nurse Consultant; r/t - related to; RSW - Regional Social Worker; ROM (range of motion) - full movement potential of a joint; Sacral wound - an open pressure ulcer on the top of the patient's small triangular bone at the base of the spinal column; Stage III Pressure Ulcer - skin develops an open, sunken hole called a crater. There is damage to the tissue below the skin. SW - Social Worker;	F 000			

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F 000	Continued From page 3 UM - Unit Manager; Unable to determine (unstageable) - pressure ulcer with 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 more severe than slough in the wound bed); w/ - with.	F 000			
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2)  §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.  §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.  §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.  §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen	F 550		11/11/19	

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F 550	<p>Continued From page 4 or resident of the United States.</p> <p>§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.</p> <p>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, it was determined that the facility failed to provide care to one randomly observed resident (R35) in a matter that maintained dignity and respect. Findings include:</p> <p>9/18/19 3:45 PM - A random observation revealed two staff members E6 (RN) and E7 (CNA) transporting R35, who was lying down on a transport chair. The staff members were pulling the chair backwards from Bay Terrace Unit, thru a long hallway in Ocean Gardens Unit to the front lobby of the facility, where medical transport was awaiting to transport R35 to a scheduled appointment.</p> <p>These findings were reviewed during the exit conference on 9/20/19 beginning at 10:15 AM with E1 (NHA), E2 (DON), E17 (Regional Nurse Consultant) and E21 (Assistant NHA).</p>	F 550	<p>The filing of this plan of correction does not constitute any admission as to any of the violations set forth in the statement of deficiencies. This plan of correction is being filed as evidence of the facility's continued compliance with all the requirements as of the completion date specified in the plan of correction for the noted deficiency. Therefore, the facility requests that this plan of correction serve as it's allegation of substantial compliance with all the requirements as of 11/11/19.</p> <p>A. Resident R35, was assessed by the facility's Unit Manager, where it was determined that there was no adverse effect to the resident from being transported backwards. E6 and E7 were identified, at the time of this report, and immediately staff were educated on the importance of transporting residents in a dignified manner, and respecting resident</p>		

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F 550	Continued From page 5	F 550	<p>rights.</p> <p>B. Residents who use transport equipment are at risk to be affected by this deficient practice. Facility wide sweep via observation will be conducted to monitor staff practice when utilizing transport equipment. Resident and Resident Representatives will be informed that the facility is engaged in house wide education. This information will be included in the activities calendar.</p> <p>C. The root cause analysis identified for this deficiency is the staff's lack of knowledge that his or her actions are considered undignified.</p> <p>All current staff will be in-serviced by the facility Staff Development Manager(SDM)/Designee, on resident rights, and treating/providing care for residents in a dignified manner. Specific examples that do not support dignified care, such as pulling a resident backward in a wheelchair, will be provided in this in-service.</p> <p>All staff will be assigned to a refresher course annually utilizing Health Care academy, the facility's electronic education system, on resident rights, and treating/providing care for residents in a dignified manner.</p> <p>During new employee orientation, the facility SDM or designee will provide specific examples of resident's rights, and exercise of rights, to ensure that all</p>		

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F 550	Continued From page 6	F 550	<p>new employees understand the importance of their actions in treating residents in a dignified manner during care, and respecting resident rights.</p> <p>D. During daily manager rounding, staff will be observed for appropriate transportation of residents in a dignified manner. Any inappropriate transportation techniques observed will be immediately corrected by the manager. Sample size for observation is 10% of daily census. Any inappropriate transportation techniques observed will be immediately corrected by the manager. Daily audit will continue until 100% compliance is achieved x 3 consecutive evaluations. Following will be a weekly audit of the same sample size x 4 weeks until 100% compliance is maintained or sustained, then monthly for the next quarter. In an event where continued non compliance is consistently below the goal, Interdisciplinary Team (IDT) will meet together with the QA Committee to review the process and revision will be made to maintain and sustain compliance. Monthly audit report will be submitted to QA committee monthly for the next quarter.</p> <p>The SDM will monitor for compliance rate in Health Care Academy for new and current employees and annually to ensure 100% compliance on providing resident rights and treating/providing care for residents in a dignified manner. Findings will be reviewed in the QAPI meetings monthly x 3 months ensure</p>		

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F 550	Continued From page 7	F 550			
F 585 SS=C	<p>Grievances CFR(s): 483.10(j)(1)-(4)</p> <p>§483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay.</p> <p>§483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.</p> <p>§483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.</p> <p>§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally</p>	F 585	<p>compliance until 100% compliance has been achieved. Findings will be reviewed in the QAPI meetings monthly x 3 months ensure compliance.</p>	11/11/19	

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F 585	Continued From page 8 (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a	F 585			

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F 585	Continued From page 9 summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on review of facility documentation, it was determined that the facility failed to establish a grievance policy that included all of the required components. Findings include:  Review of the facility's Grievance and Concerns/Complaint Policy (revised and adopted on 11/28/16) lacked evidence of the following required components: - name of the grievance official; - ensuring notification and/or postings of the grievance official's contact information with whom a grievance can be filed; - a reasonable expected time frame for completing the review of the grievance; - ensuring that all written grievance decisions include the date that the written decision was	F 585	A. No Residents were identified as a result this deficient practice. No corrections are required.  B. All residents have the potential to be affected, however none were identified and therefore no corrective action is required.  C. The root cause analysis was completed and determined that the Grievance Policy written on 11/28/16 did not include all required components. The Grievance Policy will be revised with the appropriate language and components. The revised policy will be reviewed at the next resident council meeting. Further,	
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F 585	Continued From page 10 issued; - the right to obtain a written decision regarding the resident's grievance.  These findings were reviewed during the exit conference on 9/20/19, beginning at 10:15 AM, with E1 (NHA), E2 (DON), E17 (Regional Nurse Consultant) and E21 (Assistant NHA).	F 585	the added components will be distributed to all residents on a daily activities flyer to ensure components are communicated to all current residents. The revised Grievance Policy will be marked as a do not alter without approval of the corporate regional consultant or the administrator.  D. The revised Grievance Policy will be reviewed monthly X 3 for accuracy and until 100 % compliance is achieved and sustained. The Grievance Policy will be reviewed annually thereafter for continued compliance and 100% is achieved. Audits results will be presented in the monthly QAPI committee monthly x3.		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4)  §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:  §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established	F 609		11/11/19	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>085037</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>09/20/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>ATLANTIC SHORES REHABILITATION &amp; HEALTH CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>231 SOUTH WASHINGTON STREET MILLSBORO, DE 19966</b>		
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F 609	<p>Continued From page 11 procedures.</p> <p>§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, interview, and review of other facility documentation as indicated, it was determined that for one (R54) out of two sampled residents reviewed for abuse, the facility failed to immediately report an allegation of physical abuse. Findings include:</p> <p>The facility policy entitled Abuse Policy and Procedure (last revised 3/7/18) included that residents shall not be subjected to abuse by anyone, including, but not limited to staff and other residents.</p> <p>"Definitions:...Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishments with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Willful, as used in this definition of abuse, means the individual must have acted</p>	F 609	<p>A. R54 did not have any injury from the incident and no corrective action can be taken for R54 to correct this deficient practice.</p> <p>B. All residents involved in a resident to resident altercation have the potential to be affected by this deficient practice. Clinical Management team will review all resident to resident incidents within the last 30 days to ensure incidents did not meet the definition of abuse.</p> <p>C. The root cause of the deficient practice is the facility's IDT interpretation of Physical Abuse as per clarification Memorandum on Reportable events, sent by the Delaware Division of Long Term Care Resident Protection on 10/3/2013- is that a Resident to Resident to Resident Physical Abuse without injury did not warrant a report, but rather investigation that is kept in a soft file at the facility</p> <p>Facility Clinical Management will utilize guidance as per Federal requirements to determine whether incidents that occur meet the criteria of a reportable incident.</p>		

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F 609	<p>Continued From page 12</p> <p>deliberately, not that the individual must have intended to inflict injury or harm...6. Investigation and Reporting... The Administrator, Director of Nursing or designee shall notify the Department of Health, via Event Reporting System electronically, or by phone in the event of the electronic system being unavailable. Reporting requirements in response to allegations of abuse, neglect, exploitation or mistreatment will be made immediately to the Administrator, DON or designee and the State Survey Agency. The facility will report these allegations immediately but no later than 2 hours of any allegation which includes...allegation involve abuse..."</p> <p>This is a repeat deficiency from the Complaint Survey ending 3/27/19 and the Annual and Complaint Survey ending 9/28/18.</p> <p>Review of R54's clinical record and the facility's incident report revealed the following:</p> <p>9/9/19 7:53 PM - The facility's incident report documented an altercation between R54 and R149 in which R149 kicked R54 in the face. Immediate action taken was to assess for injury to R54 and none was found.</p> <p>9/9/19 10:39 AM - A progress note documented "Writer was informed that resident was sitting out by the dining room when another resident [Name of R149] came by and kicked [R54] in the face. Skin checked, no injury found. When asked resident by writer and unit manager if [R54] was kicked [R54] said yes..."</p> <p>There was lack of evidence that the above allegation of physical abuse by R149, a resident with a history of physical aggression toward</p>	F 609	<p>Facility will re-visit the process of IDT review and discussion of Resident to Resident incidents. The team discussion will include discussion if the incident meets the definition of abuse then such incident will be reported timely to the state.</p> <p>All staff/new hires will be in-serviced by Staff Development/Designee Regarding resident to resident incidents and abuse reporting following the federal guidance.</p> <p>D. Daily audit of all resident to resident incidents by NHA/Designee will be conducted to ensure all resident to resident incidents did not meet the definition of abuse will be conducted to ensure incident that meets the definition of abuse is reported to state agency until 100% compliance is achieved x 3 consecutive evaluations. Following will be a weekly audit until 100% is consistently achieved x 4 evaluations, then monthly for the next quarter or until 100% is consistently achieved x 3 evaluations. In an event where continued non compliance is consistently below the goal, Interdisciplinary Team (IDT) will meet together with the QA Committee to review the process and revision will be made to maintain and sustain compliance. Monthly audit report will be submitted to QA committee monthly for the next quarter.</p>		

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F 609	Continued From page 13 others, was reported immediately to the State Agency.  9/19/19 4:30 PM - An interview was conducted with E1 (NHA), E2 (DON) and E17 (RNC) related to the above incident. E2 confirmed that the facility was aware of the above incident, in which R149 kicked R54 in the face and E2 confirmed that the facility did not report this to the State Agency. E1 and E17 verbalized that the reason for not reporting this incident was that the action by R149 was not willful and in addition, there was no injury inflicted to R54. E1 verbalized that currently, the facility's intervention was to monitor R149 every 15 minutes to prevent further incidents.  Despite the fact that the facility's policy further defined "willful", as it related to the definition of abuse, the facility incorrectly concluded that R149's action was not deliberate, thus, they failed to identify this as an allegation of physical abuse.  These findings were reviewed during the exit conference on 9/20/19 beginning at 10:15 AM with E1 (NHA), E2 (DON), E17 (Regional Nurse Consultant) and E21 (Assistant NHA).	F 609			
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;	F 622		11/11/19	

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F 622	<p>Continued From page 14</p> <p>(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;</p> <p>(C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;</p> <p>(D) The health of individuals in the facility would otherwise be endangered;</p> <p>(E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or</p> <p>(F) The facility ceases to operate.</p> <p>(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.</p> <p>§483.15(c)(2) Documentation. 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</p>	F 622		
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F 622	Continued From page 15 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 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 record review and interview, it was	F 622	A. R150 is no longer in the facility. No		

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F 622	<p>Continued From page 16</p> <p>determined that the facility failed to ensure that information was provided to the receiving provider for one (R150) out of four residents sampled for hospitalization. The facility failed to include resident care plan goals in the transfer/discharge information. Findings include:</p> <p>The facility's "Transfer and Discharge Requirements Policy" with a revision date of 11/28/16, revealed the following: "Information provided to the receiving provider will include a minimum of the following: ... Comprehensive care plan goals."</p> <p>The following was reviewed in R150's clinical record:</p> <p>8/8/19 - R150 was transferred to the hospital.</p> <p>9/19/19 - untimed - An interview with E2 (DON) revealed that an interagency report was sent with R150 when she was transferred to the hospital on 8/8/19. Review of R150's chart appeared to lack evidence that comprehensive care plan goals were forwarded. E2 admitted that all required documentation might not have been sent, but she would check another location.</p> <p>9/19/19 at 1:23 PM - An interview with E17 (Regional Nurse Consultant) confirmed that care plans including goals were not sent with R150 at the time of the 8/8/19 transfer to the hospital.</p> <p>Based on the foregoing circumstances, it was determined that the facility failed to provide comprehensive care plan goals to another facility at the time of resident transfer.</p> <p>These findings were reviewed during the exit</p>	F 622	<p>corrective action needed.</p> <p>B. All residents transferred out have the potential to be affected by the deficient practice. Unit Managers/Designee will conduct an audit on all residents transferred out within the last 14 days to determine whether care plan goals were sent. No corrective action can be taken for resident□s previously transferred out to the hospital.</p> <p>Facility identified the deficient practice prior to the survey. An on going plan of correction was in place at the time the deficient practice was identified by the surveyors. This plan of correction was provided to the surveyors prior to exit for review. At the time of survey, the facility was compliant since the POC was implemented.</p> <p>C. The root cause of the deficient practice is that the licensed nurse responsible for the transfer of this resident was unaware of the importance of ensuring that the care plan goals is to be sent out with the resident.</p> <p>All licensed staff and licensed new hires will be in-serviced by Staff Development/Designee with the process to ensure paperwork including care plan goals is sent with resident during transfer.</p> <p>A transfer packet checklist was revised to include paperwork required to be copied and sent with resident during transfer. The copied packet will be placed</p>		

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F 622	Continued From page 17 conference on 9/20/19 beginning at 10:15 AM with E1 (NHA), E2 (DON), E17 (Regional Nurse Consultant) and E21 (Assistant NHA).	F 622	in a binder on each unit. Nursing supervisor on duty at the time of a resident transfer to the hospital will be required to review with the licensed nurse on duty that all applicable transfer paperwork is included in the transfer packet.  Daily, the binder will be checked by the Unit Manager/Designee to ensure compliance.  D. Daily audits will be conducted by Unit Manager/Designee of all residents who were transferred to the hospital to ensure required paperwork was sent with the resident and proof of requirement is in place until 100% compliance is achieved x 3 consecutive evaluations. Following will be a weekly audit until 100% compliance is consistently achieved x 4 evaluations, then monthly for the next quarter or until 100% or higher is consistently achieved x 3 evaluations. In an event where continued non compliance is consistently below the goal, Interdisciplinary Team (IDT) will meet together with the QA Committee to review the process and revision will be made to maintain and sustain compliance. Monthly audit report will be submitted to QA committee monthly for the next quarter.		
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-	F 623		11/11/19	

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F 623	<p>Continued From page 18</p> <p>(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.</p> <p>(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</p> <p>(iii) Include in the notice the items described in paragraph (c)(5) of this section.</p> <p>§483.15(c)(4) Timing of the notice.</p> <p>(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.</p> <p>(ii) Notice must be made as soon as practicable before transfer or discharge when-</p> <p>(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;</p> <p>(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;</p> <p>(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;</p> <p>(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or</p> <p>(E) A resident has not resided in the facility for 30 days.</p> <p>§483.15(c)(5) Contents of the notice. The written</p>	F 623			

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F 623	<p>Continued From page 19</p> <p>notice specified in paragraph (c)(3) of this section must include the following:</p> <p>(i) The reason for transfer or discharge;</p> <p>(ii) The effective date of transfer or discharge;</p> <p>(iii) The location to which the resident is transferred or discharged;</p> <p>(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;</p> <p>(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;</p> <p>(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and</p> <p>(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.</p> <p>§483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information</p>	F 623			

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F 623	<p>Continued From page 20 becomes available.</p> <p>§483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for three (R87, R88 and R150) out of four residents sampled for hospitalization the facility failed to provide the resident and/or responsible party a notice of appeal for transfer/discharge that included the contact information of the entity that handles appeals. Findings include:  Review of the facility's Transfer/Discharge Notice documented " ...You have the right to appeal the decision to transfer or discharge. If you disagree with this transfer or discharge, you have the right to appeal. Please contact the individual below regarding the bed hold policy or for assistance in preparing an appeal form ..." The contact information was for the facility's Director of Social Services and not the State of Delaware Division of Health Care Quality that serves as the appeal entity.  1. The following was reviewed in R88's clinical record:  9/3/19 9:35 PM - A nursing progress note</p>	F 623	<p>A. R87 will be provided with a revised Transfer/Discharge notice that indicates the appropriate State agency responsible for appeals. R88 is discharged from the facility. No further correction needed. R150 is discharged from the facility. No further correction needed.</p> <p>B. All residents discharged from the facility have the potential to be affected by this deficient practice. An audit by the Social Services/Designee will be conducted on all residents discharged within the last 14 days to determine if incomplete appeals information was provided. Any resident identified with incomplete information will be sent a revised Transfer/Discharge Notice.</p> <p>C. The root cause analysis revealed that the manner in which the form was written led to possible misinterpretation of the appropriate agency to appeal the discharge or transfer through. The</p>		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>085037</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>09/20/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>ATLANTIC SHORES REHABILITATION &amp; HEALTH CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>231 SOUTH WASHINGTON STREET</b> <b>MILLSBORO, DE 19966</b>		
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F 623	<p>Continued From page 21</p> <p>documented that the resident was transferred to the hospital via 911.</p> <p>9/3/19 - The facility Transfer/Discharge Notice was completed indicating that the resident and the resident representative were informed of the transfer. The reason for transfer was "unresponsive", so it was unclear how the resident was actually informed.</p> <p>9/19/19 (untimed) - During an interview with E1 (NHA) and E17 (Regional Nurse Consultant), it was confirmed that the Transfer/Discharge form included the facility's social worker as well as other advocacy agencies, but did not include the State agency responsible for appeals.</p> <p>2. The following was reviewed in R150's clinical record:</p> <p>8/8/19 - R150 was transferred to the hospital.</p> <p>8/8/19 - The facility Transfer/Discharge Notice was completed and provided to R150. Although the notice explained that the resident had appeal rights, the contact information for the State entity receiving the appeals was not included on the form.</p> <p>3. Review of R87's clinical record revealed:</p> <p>7/16/19 12:45 PM - A nursing progress note documented that R87 was transferred to the hospital via 911 for a "worsening wound." The note also documented that the resident was in agreement with the transfer.</p> <p>7/16/19 - The facility Transfer/Discharge Notice was completed indicating that the resident and</p>	F 623	<p>Transfer/Discharge Notice will be revised to provide the appropriate state agency information responsible for appeals. The Social Services Director or designee will re-educate the social services department on the revised Transfer/Discharge Notice.</p> <p>D. A daily audit of Transfers/Discharge notices will be conducted by the Social Services Director or Designee to ensure that notices contain correct information until 100% compliance is achieved x 7 consecutive evaluations. Following will be weekly audits x 4 until 100% compliance is consistently achieved x 4 evaluations, then monthly for the next quarter or until 100% is consistently achieved x 3 evaluations. In an event where continued non compliance is consistently below the goal, Interdisciplinary Team (IDT) will meet together with the QA Committee to review the process and revision will be made to maintain and sustain compliance. Monthly audit report will be submitted to QA committee monthly for the next quarter.</p>		

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F 623	Continued From page 22 the resident representative were informed. Although the notice explained that the resident had appeal rights, the contact information for the State entity receiving the appeals was not included on the form.	F 623			
F 661 SS=D	<p>These findings were reviewed during the exit conference, on 9/20/19 beginning at 10:15 AM, with E1 (NHA), E2 (DON), E17 (Regional Nurse Consultant) and E21 (Assistant NHA).</p> <p>Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv)</p> <p>§483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements</p>	F 661			11/11/19

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F 661	<p>Continued From page 23</p> <p>that have been made for the resident's follow up care and any post-discharge medical and non-medical services.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview it was determined that for one (R174) out of two residents reviewed for discharge the facility failed to ensure the discharge summary was complete. For R174, the facility failed to have a recapitulation of the resident's stay, physician follow-up information, home care information and a reconciliation of the pre and post discharge medications. Findings include:</p> <p>The following was reviewed in R174's clinical record:</p> <p>6/11/19 - R174 was admitted to the facility for rehabilitation post hospitalization.</p> <p>6/18/19 - The admission MDS documented that R174 expected to be discharged back to the community.</p> <p>7/22/19 - A care plan was written for the potential for discharge with a goal that resident would be discharged home when rehabilitation/self-care goals were met. Interventions included that a post discharge plan would be completed and provided to the resident / representative.</p> <p>8/5/19 - Review of the facility's "Transition Booklet: Pathways to Independence (TOC)" used by the facility for discharge instructions revealed the following information was missing: -all demographic information, except the resident's name was missing from page one, including the discharge destination and</p>	F 661	<p>A. R174 was discharged and no further action is needed.</p> <p>B. All residents discharged have the potential to be affected by the deficient practice. All residents discharged within the past 14 days will be reviewed by Interdisciplinary Team (IDT) to ensure the discharge care summary has been completed. Any resident identified with an incomplete discharge care summary (also known as the Transition of Care Booklet -TOC) will be completed. The discharged resident will then be contacted by the Social Services Department and will be provided with the updated information in a format of their choice.</p> <p>C. The root cause analysis revealed that the IDT or their designees were not completing the TOC Booklet timely. The following departments responsible for completion of the TOC Booklet, Nursing Management (Unit Managers, DON, ADON), Social Services and the Director of Rehabilitation will be re-in- serviced by the Staff Development/Designee on the TOC Booklet guidelines including the appropriate timeframes for completion. The TOC booklet, for all scheduled discharges will be reviewed one day prior to discharge, daily in the clinical morning meeting by the IDT to ensure that all required discharge components are</p>		

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F 661	Continued From page 24 transportation for discharge. -advanced directive information. -the name of the doctor and follow-up medical care information. -home health care information. -medication log.  9/19/19 1:25 PM - During an interview with E10 (corporate social worker) it was revealed that the TOC was complete in the EMR, but E10 was unsure why the copy signed by the resident was incomplete. The facility was unable to provide the completed TOC, the recapitulation of the resident stay and the reconciliation of medications.  These findings were reviewed during the exit conference on 9/20/19 beginning at 10:15 AM with E1 (NHA), E2 (DON), E17 (Regional Nurse Consultant) and E21 (Assistant NHA).	F 661	completed.  D. Daily audit of all the TOC booklet will be conducted by ADON/Designee to ensure the TOC Booklet is appropriately completed until 100% compliance is achieved x 3 consecutive evaluations. Following will be a weekly audit of 50% sample of all TOC completed until 100% is consistently achieved x 4 evaluations, then monthly of the same sample size for the next quarter or until 100% is consistently achieved x 3 evaluations. In an event where continued non compliance is consistently below the goal, Interdisciplinary Team (IDT) will meet together with the QA Committee to review the process and revision will be made to maintain and sustain compliance. Monthly audit report will be submitted to QA committee monthly for the next quarter.		
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, interviews and review of other facility documentation, as indicated, the facility failed to ensure that code status was	F 678	A. Resident #35 had no negative outcome to relate to this deficiency. The resident representative was	11/11/19	

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F 678	<p>Continued From page 25</p> <p>accurate and congruent in all facility documents for two (R35 and R138) out of 167 sampled residents. This discrepancy put these two (R35 and R138) residents at immediate jeopardy (IJ) of a serious adverse outcome by not having a confirmed, accurate code status in the event of a medical emergency. These inaccuracies could result in CPR being administered to a resident requesting to not be resuscitated (DNR) or CPR not being performed on a resident requesting that all life sustaining measures be performed (Full Code). The IJ was identified on 9/16/19 at 5:25 PM and was abated on 9/16/19 at 8:00 PM. Findings include:</p> <p>The facility policy entitled, "Advanced Directives/CPR Policy" (last revised 11/26/16), does not address how staff should verify code status. With regard to procedure, the policy stated the following:</p> <p>3...A resident admitted without advanced directives... will be deemed a full code....</p> <p>5. Upon admission to the facility, the admitting nurse will ask resident desired code status. If the resident is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advanced directive, the facility may give advanced directive information to the individual's resident representative...</p> <p>10. Information about whether or not the resident has executed an advanced directive shall be displayed prominently in the medical record.</p> <p>1. 9/16/19 12:14 PM - A review of R35's care plan and documents in his chart reflected "do not resuscitate" (DNR), yet R35's computerized orders reflected that he was a full code. The electronic chart code status display ribbon was</p>	F 678	<p>contacted and current code status was discussed with no changes made to the medical record. The MD was notified and an order was obtained to reflect the current DNR status of the resident.</p> <p>Resident #138 had no negative outcome related to this deficiency. The code status sticker was removed. NO further action is needed for this resident. Code status is correct as reflected in the medical record.</p> <p>B. Audits were conducted on all residents currently residing in the facility on 9/16/19. Audits verified that code status orders, resident care plans and Advanced Directives <input type="checkbox"/> matched. Any discrepancies identified were corrected. On going admissions and readmissions were audited to ensure compliance is sustained.</p> <p>C. The Root cause leading to this deficiency: a timely review was not conducted on a recently admitted resident to clarify his/her current code status, and electronic code status orders and care plans were not updated. The sticker on chart of the medical record was not updated to reflect the current code status of the resident.</p> <p>1. Code status stickers are no longer used to verify code status.</p> <p>2. Upon admission the licensed nurse, will review code status of the resident. If the code status is full code,</p>		

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F 678	<p>Continued From page 26 blank and did not list either DNR or a full code status.</p> <p>2. 9/16/19 - untimed - A review of R138's hard chart and computerized profile confirmed that she was a DNR, yet the sticker on the front of her chart reflected that R138 was a full code.</p> <p>It was unclear how staff would know whether to administer life saving measures or not in the event that R35 or R138 was found unresponsive.</p> <p>The following interviews were conducted with staff about determining the code status of residents in the facility:</p> <p>9/16/19 at 3:00 PM - An interview with E21 (UM) revealed that only (residents with a) DNR will have an advanced directive (section in the chart). Full code (charts) will be blank, meaning the code status was clarified.</p> <p>9/16/19 at 4:05 PM - An interview with E13 (Unit Manager) revealed that in order to confirm code status, one staff member would check the profile on the computer and another staff member would check the paper chart.</p> <p>9/16/19 at 5:15 PM - E4 (RN Supervisor) reported that she looks in the EHR, looks for a DNR sticker on the chart, an advanced directive clarification on the signed treatment Limitation DNR order form, and on the computer next to the resident's name. E4 stated that the doctor's order auto-populates the code status in the EHR (next to the resident's name).</p> <p>9/16/19 at 5:17 PM - An interview with E23 (LPN) revealed that she looks in the EHR resident</p>	F 678	<p>and the resident is alert and oriented x3, the nurse will verify this with the patient, call the MD and obtain an order. The order will be placed in the electronic medical record. If there is no available code status, and the resident is cognitively impaired, the resident will remain a full code until the appropriate responsible party is contacted and clarity is obtained. The MD will then be notified and orders will placed in the electronic medical record under resident profile.</p> <p>3. Code status order sets in PCC were initiated on 9/16/19 so that code status orders will be reflected at top each resident's profile for licensed nurses to immediately see the code status of the resident.</p> <p>4. In the event the electronic medical record is unavailable for code status review, license staff will revert to the hard chart-advance directives section to obtain the resident's code status.</p> <p>5. The clinical leadership team will review all new admissions code status, and any code status changes in the daily morning clinical meeting to ensure there is congruence with electronic medical orders, care plans, and advanced directives.</p> <p>6. All licensed nurses currently on duty were immediately educated by the facility's Staff Development Nurse on the policy change, as well as the process for identifying a resident's code status. No</p>		

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F 678	<p>Continued From page 27 profile for the code status.</p> <p>9/16/19 5:20 PM - An interview with E22 (LPN) stated that she looks in the EHR, hard chart, report sheet, sticker on the front of the chart, the advanced directive section of the hard chart, and by the signed treatment limitations DNR form in the hard chart.</p> <p>9/16/19 - untimed - An interview with E24 (LPN) revealed that she would check the sticker on the front of the hard chart or the EMAR for code status.</p> <p>9/16/19 - at approximately 5:40 PM - E1 (NHA), E2 (DON) and E17 (Regional Nurse Consultant) were notified by the survey team that an IJ was identified when two current residents reviewed were found to have inconsistencies in DNR / full code status.</p> <p>9/16/19 at 7:44 PM - E1 (NHA) provided the abatement plan for the IJ.</p> <p>9/16/19 at 8:00 PM - The IJ was abated after the following was completed: all resident records were audited by the facility; R35's and R138's code statuses were verified and updated; the facility policy was revised to reflect the location of each resident's code status; facility staff present were educated on the location of each resident's code status; and no staff would work until they were educated on the current policy for determining code status.</p> <p>These findings were reviewed during the exit conference on 9/20/19 beginning at 10:15 AM with E1 (NHA), E2 (DON), E17 (Regional Nurse Consultant) and E21 (Assistant NHA).</p>	F 678	<p>licensed staff will be allowed to work prior to receiving this education. The facility's Staff Development Nurse will educate all licensed nurses in new hire orientation, of the facility's Advanced Directives/CPR Policy specific to the management of identifying the code status of a resident utilizing the resident profile in electronic medical record. Ongoing education will be provided on a biannual schedule to licensed staff via the Organizations Health Care Academy to ensure ongoing awareness of the facility's policy and expectation.</p> <p>7. The Corporate Social Work Consultant will provide education to the facility's social workers on ensuring that care plans reflect the correct code status of the resident.</p> <p>D. Daily audit will be conducted by Unit Manager/Designee of all new admissions/readmissions as well as residents with change in Code status to ensure Code status is accurate per resident preference and documentation in the medical records until 100% compliance is achieved x 3 consecutive evaluations. Following will be a weekly audit until 100% compliance is consistently achieved x 4 evaluations, then monthly for the next quarter or until 100% is consistently achieved x 3 evaluations. In an event where continued non compliance is consistently below the goal, Interdisciplinary Team (IDT) will meet together with the QA Committee to review the process and revision will be</p>		

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F 678	Continued From page 28	F 678	made to maintain and sustain compliance. Monthly audit report will be submitted to QA committee monthly for the next quarter.		
F 684 SS=D	<p>Quality of Care CFR(s): 483.25</p> <p>§ 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, it was determined that the facility failed to ensure that weights were monitored for one (R138) out of one residents sampled for care concerning edema (swelling). Findings include:</p> <p>The following was reviewed in R138's clinical record:</p> <p>8/26/19 - An electronic doctor note reflected "lower extremity, prominent edema noted. Edema +1. Start Lasix (a diuretic medication used to reduce extra fluid in the body) 20 mg by mouth every day."</p> <p>9/11/19 - An electronic NP note reflected the following: "trace edema bilateral lower extremities. Discontinue Lasix. Monitor weights."</p> <p>9/15/19 at 3:00 PM - R138 was noted to have</p>	F 684	<p>A. There was no negative outcome from this deficiency. An order for R138 weights every two weeks was obtained on 9/17/19.</p> <p>B. Residents seen/consulted by the nurse practitioner have the potential to be affected by this deficient practice. Post Acute Physician Partners (PAPP) designee will review all Nurse Practitioner (NP) notes within the last two weeks will be reviewed to ensure recommendations for weights monitoring are carried out.</p> <p>C. The root cause of the deficient practice was NP did not notify staff of the need for weight monitoring or an order was placed to initiate monitoring.</p> <p>Providers will be in-serviced by the</p>	11/11/19	

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F 684	Continued From page 29 mild edema in her right lower extremity.  9/17/19 at 11:25 AM - An interview with E13 (UM) revealed that R138's edema waxes and wanes. The surveyor and E13 reviewed the 9/11/19 NP note was where the NP stated, "monitor weights, " yet there was no order for this. E13 was uncertain why there was no order for resident weights. E13 stated that she would clarify with the NP.  9/17/19 at 11:43 AM - An electronic note confirmed the following: "discussed with... CRNP regarding clarification for monitoring weights due to Lasix was dc'd (discontinued). Staff are to continue to monitor for edema, with .... CRNP stated to monitor weights every two weeks. Family phoned to update."  The facility failed to clarify how often R138 was to have weights done when an order was written on 9/11/19 to "monitor weights,: until it was brought to the facility's attention by the surveyor on 9/17/19.  These findings were reviewed during the exit conference on 9/20/19 beginning at 10:15 AM, with E1 (NHA), E2 (DON), E17 (Regional Nurse Consultant) and E21 (Assistant NHA).	F 684	Medical Director on appropriate carry over of recommendations by writing of an order or informing the nurse to receive a telephone order for their recommendations. Effective immediately, Medical providers will exit with a licensed nurse, or unit Manager prior to leaving the unit. The purpose of this exit is to discuss all the patients that were seen by the provider and complete a review of all orders and recommendations made to ensure continuity of care to each resident.  D. Daily audit of all provider's notes will be conducted by the Medical Director/Designee to ensure all recommendations by providers in their notes are carried out in the medical records until 100% compliance is achieved x 3 consecutive evaluations. Following will be a weekly audit of 50% sample of progress notes until 100% compliance is consistently achieved x 4 evaluations, then monthly of 20% sample of progress notes for the next quarter or until 100% is consistently achieved x 3 evaluations. In an event where continued non compliance is consistently below the goal, Interdisciplinary Team (IDT) will meet together with the QA Committee to review the process and revision will be made to maintain and sustain compliance. Monthly audit report will be submitted to QA committee monthly for the next quarter.		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)	F 686		11/11/19	

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F 686	<p>Continued From page 30</p> <p>§483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers.</p> <p>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 record review, interview, observation and review of other facility documentation it was determined that for one (R121) out of one residents reviewed for pressure ulcers, it was determined that the facility failed to ensure that a resident with a pressure ulcer received the care and services necessary to promote healing and to prevent new pressure ulcers from developing. The facility failed to ensure that R121 was not positioned on her back as directed in the plan of care. Findings include:</p> <p>A facility policy entitled Pressure Ulcers/Skin Breakdown (unknown revision date) included: The purpose of this policy is to ensure appropriate assessment to determine risks for breakdown and ensure appropriate interventions initiated.</p> <p>Review of R121's clinical record revealed:</p> <p>11/8/16 - R121 was admitted to the facility after a stroke with left-sided weakness.</p>	F 686	<p>A. R121's care plan stated avoid positioning the resident on her back. Care plan intervention was revised to read resident's preference to be on her back with meals and as per her request on 10/14/19. Area resolved 10/8/19.</p> <p>B. Residents with pressure ulcers have the potential to be affected by this deficient practice. All residents plan of care for pressure ulcers will be reviewed to ensure plan of care reflects current individualized intervention as per resident's preferences and promote wound healing.</p> <p>C. The root cause of the deficient practice was the plan of care did not reflect resident's choice and preferences of being on her back with meals and per request. This deficient practice did not result in worsening of wounds nor delayed wound healing. The wound was resolved</p>		

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F 686	<p>Continued From page 31</p> <p>7/30/19 - A facility contracted wound nurse documented that R121's sacral wound measured 0.7 x 0.3 x 0.1 centimeters and was a Stage III pressure ulcer.</p> <p>8/1/19 - R121's care plan for "an actual Stage III pressure ulcer r/t (related to) immobility included: "Avoid positioning the resident on (her) back."</p> <p>8/6/19 - A facility contracted wound nurse documented that R121's sacral wound measurements were 0.7 x 0.3 x UTD (unable to determine) centimeters and that the wound was worse related to the wound bed was yellow and unable to determine the depth of the wound (unstageable).</p> <p>8/12/19 - Physician's orders included: Assist turn and repositioning q2 hour (every two hours) with skin check.</p> <p>8/25/19 - A review of R121's fourteen day (most recent) MDS revealed that R121 was non-ambulatory, required extensive assist of two people to be repositioned in bed, and was at risk for pressure ulcers.</p> <p>The following dates and times R121 was observed to be positioned on her back: 9/17/19 8:47 AM; 9/17/19 1:24 PM; 9/18/19 7:55 AM; 9/19/19 8:47 AM; 9/19/19 10:06 AM; 9/19/19 10:45 AM; 9/19/19 11:05 AM and 9/20/19 7:23 AM.</p> <p>9/20/19 9:35 AM - During an interview with E5 (UM) and E3 (QA), it was confirmed that the individualized intervention to avoid positioning R121 on her back was in the current care plan.</p>	F 686	<p>on 10/8/19.</p> <p>New admissions/Readmissions and new wounds identified will be reviewed by Unit Manager and Wound Nurse to ensure plan of care and care tracker reflects individualized intervention to reflect resident preference as well as promote wound healing in the plan of care. Each week at the facility's Weekly Risk meetings, the IDT will review all residents with pressure ulcer care plans to ensure that the plan of care reflects the appropriate intervention.</p> <p>Nursing Management team will be in-serviced by Staff Development/Designee on appropriate plan of care for residents with pressure ulcers. Education will focus on resident's personal preference as it relates to interventions to promote wound healing.</p> <p>D. Daily audit will be conducted by Unit Manager/Designee of all residents who were admitted with pressure ulcers and newly acquired pressure ulcers to ensure plan of care and care tracker reflects individualized intervention as per resident preference and as it relates to wound healing until 95% compliance is achieved x 3 consecutive evaluations. Following will be a weekly audit until 95% or higher compliance is consistently achieved x 4 evaluations, then monthly for the next quarter or until 95% or higher is consistently achieved x 3 evaluations. In an event where continued non compliance is consistently below the goal,</p>		

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F 686	Continued From page 32 E5 also confirmed that the intervention was not in the Care Tracker to alert the CNA's to carry out the intervention. E3 stated that it was a good intervention for wound healing, and that staff should have been following the plan of care to avoid positioning R121 on her back.	F 686	Interdisciplinary Team (IDT) will meet together with the QA Committee to review the process and revision will be made to maintain and sustain compliance. Monthly audit report will be submitted to QA committee monthly for the next quarter.		
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 record review and interview it was determined that for two (R35 and R88) out of three residents reviewed for accidents, the facility failed to ensure adequate supervision and assistive devices to prevent accidents. Findings include:  1. The following was reviewed in R88's clinical record:  8/3/19 - R88 was admitted to the facility.  8/5/19 - Review of a facility incident report documented that while R88 was being	F 689		11/11/19	
			1.  A. R88 is no longer in the facility. No further correction needed. E7 was re-educated on 8/6/19.  B. All residents using the facility bus have the potential to be affected by this deficient practice. The Maintenance Director/Designee will conduct random observations of residents scheduled for transport within the next seven days to ensure staff is following appropriate process for securing wheelchairs during		

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F 689	<p>Continued From page 33</p> <p>transported to dialysis in a van owned by the facility, the resident fell out of the wheelchair. The report documented that the resident complained of a headache upon returning to the facility and was administered Tylenol. The report concluded that the wheelchair restraint was not properly buckled in the van.</p> <p>8/5/19 1:28 PM - A statement from E7 (CNA), who was taking R88 to the appointment, documented, "I secured the back wheels (wheelchair) and placed a seatbelt on [R88's] waist but in haste to get to the appointment I forgot to secure the front wheels. While on the turn to Seaford the resident fell backwards."</p> <p>8/5 - 8/6/19 - The record included neurological assessments done for 23 hours post-accident.</p> <p>8/6/19 - E7 (CNA) was provided a refresher training on safely securing a resident for transport.</p> <p>8/7/19 - A Certification of Road Test was completed with E7 (CNA).</p> <p>There was no evidence that E7's (CNA) ability to secure residents for transport was monitored after the 8/6/19 re-education.</p> <p>8/10/19 - Review of the admission MDS reflecting the resident's abilities over the past seven days revealed that R88 required extensive assistance with one-person physical assist for bed mobility, transfer, locomotion and dressing.</p> <p>8/19/19 - During an interview with E1 (NHA) and E17 (Regional Nurse Consultant), it was confirmed that R88's accident occurred due to the</p>	F 689	<p>transport.</p> <p>C. Root cause analysis revealed the employee failed to secure one of the straps on the wheelchair to ensure the resident is secured prior to transport.</p> <p>All new hires for the position will be in-serviced by the Director of Maintenance Department/Designee on how to appropriately secure wheelchairs for transport. A follow-up monitoring/or return demonstration will be completed to verify competency.</p> <p>D. Daily audit will be conducted by Director of Maintenance Department/Designee of all residents scheduled on transport with the staff to ensure compliance with securing wheelchair while on transport until 100% compliance is achieved x 3 consecutive evaluations. Following will be a weekly audit until 100% compliance is consistently achieved x 4 evaluations, then monthly for the next quarter or until 100% is consistently achieved x 3 evaluations. In an event where continued non compliance is consistently below the goal, Interdisciplinary Team (IDT) will meet together with the QA Committee to review the process and revision will be made to maintain and sustain compliance. Monthly audit report will be submitted to QA committee monthly for the next quarter.</p> <p>2.</p>		

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F 689	<p>Continued From page 34</p> <p>wheelchair not being secured by the transport staff. There was no evidence that E7 (CNA) was monitored to ensure compliance with securing residents for transport.</p> <p>2. Review of R35's clinical record revealed the following:</p> <p>4/1/19 - R35 was admitted to the facility with diagnosis including dementia with behavior disturbances and anxiety disorder.</p> <p>4/1/19 - A care plan was written for being at risk for fall related injury as evidenced by impaired balance and mobility, and a previous fall. The goal was that R35 would not sustain a fall related injury by utilizing fall precautions through the next 30 day review period. The resident experienced multiple falls during the review period with the most recent fall occurring on 4/30/19. The interventions included to encourage call bell use, resident can be spontaneous with getting up and or transfers without requesting assistance due to impaired cognition, encourage resident to be in common area, encourage to be in supervised area when out of bed, frequent checks, frequent monitoring when up and awake; ensure resident is not in close proximity with a female resident; modified 1:1; resident will be encouraged to sit next to the staff in charge of seating schedule; if resident wanders, offer activity or ask assistance from another staff to supervise resident; or when resident tries to scoot/restless while in wheelchair, lock brakes on wheelchair before transferring, educate/remind resident to request assistance prior to ambulation, 11-7 to sit outside resident's room for supervision when staff not doing resident care.</p>	F 689	<p>A. R35 is maintained in close proximity with staff when on sitting schedule. During acute phase of restlessness R35 is being watched on 1:1 a basis.</p> <p>B. All residents with multiple falls potentially caused by restlessness will potentially be affected by this deficient practice. IDT will conduct audit and review on residents noted with multiple falls potentially caused by restlessness within the past 30 days to ensure appropriate interventions are in place.</p> <p>C. The root cause analysis of the deficient practice was the nurse was unable to prevent or break the resident sliding out of the chair due to the barrier of the nursing station directly in between the nurse and the resident.</p> <p>Nursing Staff and new hires will be in-serviced by Staff Development/Designee regarding residents requiring close supervision are to remain within arm's length of the staff conducting the monitoring.</p> <p>D. Daily observation audit will be conducted to ensure all residents identified with multiple falls potentially due to restlessness are being monitored/supervised as per plan of care until 100% compliance is achieved x 7 consecutive days. Following will be a weekly audit of 50% sample of identified residents until 100% is consistently</p>		

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F 689	Continued From page 35  4/9/19 (Most recent revision date of 4/30/19) - A care plan was written for R35's use of anti-anxiety medication related to adjustment issues, anxiety disorder, physical aggression, and agitation as evidenced by behavior of attempting to throw self on floor. Interventions included to identify needs such as toileting, food, fluids, rest; 1:1 during acute phase; monitor in common area, and Namaste room.  7/9/19 - The quarterly MDS assessment documented that R35 was severely impaired for daily decision making, required extensive assistance of one person for transfer and walking in room. In addition, R35 was not steady, when moving from a seated to a standing position and was only able to stabilize with staff assistance.  9/2/19 4:30 AM - A nurse's note, by E11 (LPN) documented that R35 pulled the bathroom callbell in another resident's room at approximately 4:15 AM and the CNA answered the callbell and found R35 in the bathroom sitting on toilet. While R35 was being assisted in the bathroom, the CNA noticed a skin tear to the left upper arm. The skin tear was cleansed with normal saline solution and a dressing was applied. The note documented that R35 had pain and PRN medication was given. Review of the eMAR documented that R35 was administered Tylenol for hip pain.  Although R35's care plan included interventions for the night shift (11:00 PM - 7:00 PM) staff to sit outside of the resident's room for supervision when staff were not doing resident care, R35 was found in another resident's bathroom on the toilet with a new skin tear to the left upper arm and a new onset of pain to the left thigh.	F 689	achieved x 4 evaluations, then monthly of the same sample size for the next quarter or until 100% is consistently achieved x 3 evaluations. In an event where continued non compliance is consistently below the goal, Interdisciplinary Team (IDT) will meet together with the QA Committee to review the process and revision will be made to maintain and sustain compliance. Monthly audit report will be submitted to QA committee monthly for the next quarter.		

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F 689	<p>Continued From page 36</p> <p>9/2/19 6:45 AM - A nurse's note by E11 (LPN) documented that while E11 was sitting at the desk at the nurses station at approximately 6:45 AM, R35 began to slowly slide himself forward and out of this chair, sliding to his knees, then laid onto the floor in a fetal position. E12 (RN Supervisor) was called to assess the resident and range of motion was assessed. R35 did not complain of pain until after being placed into a chair and stated that his thigh was hurting. As R35 continued to slide down in the wheelchair, he was transferred into a recliner chair.</p> <p>9/17/19 3:05 PM - 3:15 PM - A random observation of R35 revealed R35 sitting a wheelchair with restlessness and attempting to stand up unassisted while attempting to enter into the nurses station with E24 (CNA) next to R35. E24 was observed verbally reminding R35 not to stand up from the wheelchair on three occasions as well as offering drinks and snacks to redirect R35's behavior.</p> <p>9/17/19 3:20 PM - An interview with E24 (CNA) revealed that R35 was never left alone by staff when R35 was in a wheelchair and R35 required close supervision.</p> <p>9/18/19 5:29 PM - E2 (DON) was interviewed who conducted the interviews with the three staff members, E11 (LPN), E15 (CNA), and E16 (CNA) who were working in the unit during the 11:00 PM - 7:00 AM shift on 9/2/19. E2 verbalized that she had questioned E11 if R35 experienced a fall prior to the observation of a skin tear and left thigh pain and E11 verbalized that R35 would not be able to get himself off the floor if R35 had fallen. In addition, E15 and E16</p>	F 689			

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F 689	<p>Continued From page 37</p> <p>denied that R35 experienced a fall prior to the new onset of pain. The surveyor inquired where was R35 physically sitting when E11 placed a call to E12 (RN Supervisor) at approximately 6:45 AM and E2 replied, "somewhere around the Nurses Station." E2 verbalized that R35 was in "eyesight of the nurse."</p> <p>9/23/19 4:40 PM - The surveyor received a return call from E11 (RN) and an interview was conducted. E11 verbalized while administering the scheduled 5:00 AM medications to other residents on 9/2/19, R35 was "right there with me most of the time" since R35 was agitated and was slouching in the wheelchair and required repeated reminders not to slouch or stand up unassisted. At approximately 6:45 AM, E11 proceeded to leave R35, outside of room 509 (a room utilized for unit activities called "Namaste") and proceeded to call E12 (RN Supervisor) due to R35's unrelieved pain with oral pain medication. While E11 was on the telephone with E12, R35 was visible from the back of the unit's nursing station and E11 observed R35 sliding himself onto the floor. E11 verbalized that this was the first time during the night shift that R35 was brought to the nursing station and was not aware of the intervention for 1:1 supervision during acute phases of agitation.</p> <p>The facility failed to provide adequate supervision to R35 resulting in a fall on 9/2/19 at approximately 6:45 AM.</p> <p>These findings were reviewed during the exit conference on 9/20/19, beginning at 10:15 AM, with E1 (NHA), E2 (DON), E17 (Regional Nurse Consultant) and E21 (Assistant NHA).</p>	F 689			

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F 730 F 730 SS=D	Continued From page 38 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 performance 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 requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on interview and review of facility documentation, it was determined that the facility failed to ensure performance evaluations were completed at least every 12 months for three (E15, E27 and E28) out of seven sampled CNAs. Findings include:  The facility policy and procedure for Certified Nursing Aides Annual Evaluation (dated 11/28/17) included, "It is the policy of this facility to complete a performance review of every nurse aide at least every 12 months and provide educational inservices based on the outcome of those reviews...The date of hire will determine the month in which the performance evaluation will be performed ...The facility allows a 30 day grace period before and after date of hire."  9/18/19 12:30 PM - Review of the latest performance evaluations for the seven selected CNAs revealed that based on their hire date, three CNA's performance appraisals were completed late:  1. E15 (CNA) had a date of hire of 5/17/10. The last performance appraisal was dated 7/4/19. 2. E27 (CNA) had a date of hire of 11/19/02. The	F 730 F 730	Past noncompliance: no plan of correction required.		10/19/19

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F 730	Continued From page 39 last performance appraisal was dated 1/15/19. 3. E28 (CNA) had a date of hire of 1/12/17. The last performance appraisal was dated 5/2/19.  9/18/19 2:30 PM - During an interview, E1 (NHA) confirmed the above findings and explained that the facility self-identified that CNA performance evaluations were not completed at least every 12 months. In addition, E1 provided a plan of correction (including staff education and audits) with a compliance date of 7/31/19.  9/20/19 9:00 AM - To confirm facility compliance, E29's (CNA) latest performance evaluation was requested. E29 had a date of hire of 8/30/16. The last performance appraisal was dated 8/27/19. Therefore, this deficiency is being cited as past-noncompliance.  These findings were reviewed during the exit conference on 9/20/19 beginning at 10:15 AM with E1 (NHA), E2 (DON), E17 (Regional Nurse Consultant) and E21 (Assistant NHA).	F 730			
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4)  §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed	F 732		11/11/19	

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F 732	<p>Continued From page 40 vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census.</p> <p>§483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors.</p> <p>§483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>§483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined, that the facility failed to post the required staffing information in a prominent place, readily accessible to residents and visitors. Findings include:  9/19/19 8:45 AM - An observation of the facility's main lobby revealed no staffing postings.  9/19/19 8:50 AM - During an interview, E1 (NHA) stated that that the federal staffing was posted on each unit.</p>	F 732	<p>A. No Residents were identified as a result this deficient practice. No corrections are required.</p> <p>B. All residents have the potential to be affected, however none were identified and therefore no corrective action is required.</p> <p>C. The root cause of the deficient practice was the Nurse Staffing Information was posted on one unit only.</p>		

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F 732	<p>Continued From page 41</p> <p>9/19/19 8:50 AM to 9:20 AM - Observations of all four nursing units revealed that the federal staffing was only posted on the Beach Cove unit which does not have a visitor entrance. Therefore, this posting was not located in a prominent place and not accessible to residents and visitors.</p> <p>9/19/19 9:20 AM - An interview with E5 (LPN, Unit Manager of Beach Cove) revealed that the federal staffing was only posted on the Beach Cove unit.</p> <p>These findings were reviewed during the exit conference on 9/20/19, beginning at 10:15 AM, with E1 (NHA), E2 (DON), E17 (Regional Nurse Consultant) and E21 (Assistant NHA).</p>	F 732	<p>Postings will be made available at both entrances of the facility which are prominent places and accessible to residents and visitors.</p> <p>D. Daily audit of will be conducted by ADON/Designee to ensure staffing posting is in place on both entrances until 100% compliance is achieved x 7 consecutive days. Following will be a weekly audit until 100% is consistently achieved x 4 evaluations, then monthly for the next quarter or until 100% is consistently achieved x 3 evaluations. In an event where continued non compliance is consistently below the goal, Interdisciplinary Team (IDT) will meet together with the QA Committee to review the process and revision will be made to maintain and sustain compliance. Monthly audit report will be submitted to QA committee monthly for the next quarter.</p>		
F 761 SS=D	<p>Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)</p> <p>§483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>§483.45(h) Storage of Drugs and Biologicals</p> <p>§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and</p>	F 761		11/11/19	

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F 761	<p>Continued From page 42</p> <p>biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and interview, it was determined that the facility failed to store and maintain drugs in accordance with acceptable professional principles by having an opened, undated bottle of eye drops in one (Ocean Gardens Front Hall) out of five medication carts inspected. Findings include:</p> <p>9/19/19 2:45 PM - An observation of the Ocean Gardens Front Hall medication cart with E23 (LPN) revealed an opened, undated bottle of eye drops (Timolol a medication to lower pressure within the eyeball) for R162. The above findings were immediately confirmed by E23.</p> <p>These findings were reviewed during the exit conference on 9/20/19 beginning at 10:15 AM with E1 (NHA), E2 (DON), E17 (Regional Nurse Consultant) and E21 (Assistant NHA).</p>	F 761	<p>A. R162's eye drop was checked. Dispense date was 9/9/19 and is within the 30 days if opened on dispense date. Eye drop was re-ordered for the resident.</p> <p>B. Residents receiving eye drops have the potential to be affected. Facility wide sweep by Unit Managers/Designee will be conducted to ensure all eye drops have a date opened. Eye drops with no open date will be reviewed and replaced as needed.</p> <p>C. The root cause of the deficient practice was determined that the nurse opened the eye drop bottle but forgot to date the bottle. Upon investigation, the dispense date was 9/9/19 which is within 30 days of opening.</p> <p>Licensed staff will be in-serviced by Staff Development/Designee on appropriate labeling of multi dose medications once opened</p>		

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F 761	Continued From page 43	F 761	<p>Daily on each shift, nurse in-charge will check all multi dose medications to ensure it is appropriately labeled. During shift round, nursing supervisors will follow up with charge nurses to ensure that multi dose medication containers are dated as required.</p> <p>D. Daily audit will be conducted by Unit Manager/Designee on all multi dose medication to ensure it is appropriately labeled once opened until 100% compliance is achieved x 3 consecutive evaluations. Following will be a weekly audit until 100% compliance is consistently achieved x 4 evaluations, then monthly for the next quarter or until 100% is consistently achieved x 3 evaluations. In an event where continued non compliance is consistently below the goal, Interdisciplinary Team (IDT) will meet together with the QA Committee to review the process and revision will be made to maintain and sustain compliance. Monthly audit report will be submitted to QA committee monthly for the next quarter.</p>		
F 880 SS=F	<p>Infection Prevention &amp; 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</p>	F 880		11/11/19	

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F 880	Continued From page 44 diseases and infections.  §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:  §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;  §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (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	F 880			

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F 880	Continued From page 45 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.  §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.  §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.  §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:	F 880		
	Based on observation, review of facility policy and procedures and review of other facility documentation, it was determined that the facility failed to review and revise the infection control policies at least annually and the facility failed to ensure that a clean room was maintained to prevent contamination of clean laundry and resident care equipment. Findings include:  1. Review of the infection control program on 9/18/19 at approximately 11:00 AM revealed: - The facility policy titled "Standard Precautions" policy was last revised and reviewed in 2007. - The facility policy titled "Infection Control Guidelines for All Nursing Procedures," under "General Guidelines" number 3, the facility stated, "employee must wash their hands for 10 - 15 seconds." This policy was revised in August		1.  A. No residents were identified as a result of this deficient practice therefore no corrective action is required.  B. All residents have the potential to be affected by this deficient practice however none have been identified therefore no corrective action is required.  C. A root cause analysis revealed that the Standard Precautions Policy and the Infection Control Guidelines for All Nursing Procedures were not reviewed annually and updated to reflect the current standards of practice for infection control. While the policy read otherwise, the	

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F 880	Continued From page 46 2012.  Infection control policies should be reviewed at least annually.  Findings were reviewed and confirmed by E2 (DON) on 9/18/19 at approximately 11:00 AM.  2. An observation of the laundry room on 9/19/19 from 10:30 AM to 11:30 AM revealed: - There was no evidence positive air pressure in the clean laundry room. - There was no evidence negative pressure in the dirty laundry room. - The laundry area did not have adequate hand washing service. The dirty laundry room did not have a handwashing sink; staff were using an utility sink for handwashing. Although, there was a handsink in the clean laundry room, the hand soap and paper towels were placed in a hard to reach location.  Findings were reviewed and confirmed by E26 (facility maintenance director) on 9/19/19 at approximately 11:00 AM.  These findings were reviewed during the exit conference, on 9/20/19, beginning at 10:15 AM with E1 (NHA), E2 (DON), E17 (Regional Nurse Consultant) and E21 (Assistant NHA).	F 880	facility staff were trained on the proper infection control measures through Healthcare Academy and according to CDC Guidelines. The current policies have been reviewed and revised to reflect any updates of current standards of practice.  Policies will be reviewed annually by the QAPI committee to ensure the most current CDC recommendations are in the body of the Guidelines and Policies. Nursing Management staff will be educated on the new Guidelines and Policy revisions by the Staff development RN/Designee.  D. The revised Standard Precaution Policy will be reviewed monthly by DON/Designee accuracy to reflect CDC guideline for hand washing for at least 15 seconds until 100 % compliance is achieved and sustained x 3 evaluations. The Standard Precaution Policy will be reviewed annually thereafter to sustain and maintain compliance. In an event where continued non compliance is consistently below the goal, Interdisciplinary Team (IDT) will meet together with the QA Committee to review the process and revision will be made to maintain and sustain compliance. Monthly audit report will be submitted to QA committee monthly for the next quarter.  2.		

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F 880	Continued From page 47	F 880	<p>A. No residents were identified as a result of this deficient practice therefore no corrective action is required.</p> <p>B. All residents have the potential to be affected by this deficient practice however none have been identified therefore no corrective action is required.</p> <p>C. The root cause analysis revealed that both the clean and dirty rooms did have positive and negative pressures that did not meet the expectations of the surveyor. The maintenance director or designee will work with a local HVAC and or a Balancing Company contractor to determine both positive (Clean) and negative (Dirty) pressures in the laundry area. Any recommendations based on the vendors' findings will be considered to maintain positive and negative pressure on both sides of the laundry room.</p> <p>The root cause analysis revealed one handwashing sink had been removed earlier on the dirty side and was not replaced at the time of removal since there is another sink on this same side. The sink on the clean side had hand washing products available but not as convenient. A new operable handwashing sink will be installed and on the dirty side of the laundry room. The clean side will have a new paper towel and soap dispenser installed to better accommodate the staff.</p> <p>D. Daily monitoring of equipment to</p>	

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F 880	Continued From page 48	F 880	<p>maintain positive and negative pressures will be conducted by the Maintenance Director/Designee until 100% compliance is achieved over 7 consecutive evaluations. Following will be a weekly audit until 100% compliance is consistently achieved x 4 evaluations, then monthly for the next quarter or until 100% is consistently achieved x 3 evaluations. In an event where continued non compliance is consistently below the goal, Interdisciplinary Team (IDT) will meet together with the QA Committee to review the process and revision will be made to maintain and sustain compliance. Monthly audit report will be submitted to QA committee monthly for the next quarter.</p> <p>Daily audit by the Maintenance Director/Designee of the handwashing facilities including the sink, soap and paper towel dispenser will be conducted to ensure operation and readily available supplies until 100% compliance is achieved x 7 consecutive evaluations. Following will be a weekly audit until 100% compliance is consistently achieved x 4 evaluations, then monthly for the next quarter or until 100% is consistently achieved x 3 evaluations. In an event where continued non compliance is consistently below the goal, Interdisciplinary Team (IDT) will meet together with the QA Committee to review the process and revision will be made to maintain and sustain compliance. Monthly audit report will be submitted to QA committee monthly for the next</p>		

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(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 880	Continued From page 49	F 880			
F 943 SS=D	<p>Abuse, Neglect, and Exploitation Training CFR(s): 483.95(c)(1)-(3)</p> <p>§483.95(c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on-</p> <p>§483.95(c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12.</p> <p>§483.95(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property</p> <p>§483.95(c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and review of facility documentation it was determined that the facility failed to ensure the required training on abuse, neglect, exploitation and misappropriation of resident property was completed for one (E31) out of ten randomly sampled staff members. Findings include:</p> <p>9/19/19 9:00 AM - Review of the facility's documented completion of required abuse and neglect training for E31 (LPN) revealed that the required training was completed on 9/18/19 - after this information was requested by the surveyor (on 9/17/19 at 10:30 am). E31 was hired on 4/3/14.</p>	F 943	<p>quarter,</p> <p>A. No residents were identified as a result of this deficient practice therefore no corrective action is required. E31 completed the Abuse and Neglect training on 9/18/19 during the survey.</p> <p>B. All residents have the potential to be affected by this deficient practice however none have been identified therefore no corrective action is required.</p> <p>Staff Development will audit all staff to identify any staff non compliant with the required training for Abuse, Neglect, Exploitation and Misappropriation of Resident Property. Staff identified to be</p>	11/11/19	

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

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>085037</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>09/20/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>ATLANTIC SHORES REHABILITATION &amp; HEALTH CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>231 SOUTH WASHINGTON STREET MILLSBORO, DE 19966</b>		
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F 943	Continued From page 50 9/19/19 10:00 AM - During an interview, E1 (NHA) confirmed that E31 completed the required training after it was requested by the surveyor.  These findings were reviewed during the exit conference on 9/20/19 beginning at 10:15 AM, with E1 (NHA), E2 (DON), E17 (Regional Nurse Consultant) and E21 (Assistant NHA).	F 943	non complaint with the education will be completing the course prior to next scheduled workday.  C. The root cause of the deficient practice is that one PRN staff in the sample did not complete the required training scheduled.  Two times a year, all staff training will be reviewed by Human Resources/Designee to ensure staffs are compliant with required in-service training.  Staff Development/Designee will in-service all staff and new hires on required trainings. This will be offered upon hire and then reviewed two times a year for compliance.  D. Staff training on Abuse, Neglect, Exploitation and Misappropriations of Resident Property will be audited monthly by Human Resources until 100% compliance is achieved x 3 evaluations for all staff. Following will be a bi-annual audit for all staff to ensure consistent compliance is sustained x 2 evaluations. In an event where continued non compliance is consistently below the goal, Interdisciplinary Team (IDT) will meet together with the QA Committee to review the process and revision will be made to maintain and sustain compliance. Monthly audit report will be submitted to QA committee monthly for the next quarter.		



**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: Atlantic Shores Rehabilitation & Health Center DATE SURVEY COMPLETED: September 20, 2019

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
<p>201</p> <p>3201.1.0</p>	<p><b>The State Report incorporates by reference and also cites the findings specified in the Federal Report.</b></p> <p>An unannounced annual and complaint survey was conducted at this facility from September 15, 2019 through September 20, 2019. The facility census the first day of the survey was 167.</p> <p>During this period an Emergency Preparedness Survey was also conducted by the State of Delaware's Division of Health Care Quality Long Term Care Residents Protection in accordance with 42 CFR 483.73.</p> <p><b>Regulations for Skilled and Intermediate Care Facilities</b></p> <p><b>Scope</b></p>	<p>Preparation and/or execution of the Plan of Correction does not constitute admission or agreement of the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law.</p> <p>This plan represents the facility's credible allegation of compliance as of 11/11/19.</p>	
<p>3201.1.2</p>	<p><b>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.</b></p> <p><b>This requirement is not met as evidenced by:</b> Cross Refer to the CMS 2567-L survey completed September 20, 2019: F550, F585, F609, F622, F623, F661, F678, F684, F686, F689, F730, F732, F761, F880, and F943</p>	<p>Cross refer to the CMS 2567-L survey completed 9/20/19 for F550, F585, F609, F622, F623, F661, F678, F684, F686, F689, F730, F732, F761, F880 and F943.</p>	<p>11/11/19</p>

Provider's Signature

Title NHA

NHA Revised

Date 10/18/19

11/4/19



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3201.5.6	<p><b>Dementia Training</b></p> <p>Nursing facilities that provide direct healthcare services to persons diagnosed as having Alzheimer's disease or other forms of dementia shall provide dementia specific training each year to those healthcare providers who must participate in continuing education programs. This section shall not apply to persons certified to practice medicine under the Medical Practice Act, Chapter 17 of Title 24 of the Delaware Code.</p> <p>The mandatory training must include: communicating with persons diagnosed as having Alzheimer's disease or other forms of dementia; the psychological, social, and physical needs of those persons; and safety measures which need to be taken with those persons. This requirement was not met as evidenced by:</p> <p>Based on interview and review of facility documentation it was determined that the facility failed to provide dementia specific training in the past year to one (E31) out of ten randomly sampled staff members. Findings include:</p> <p>9/19/19 9:00 AM - Review of the facility's documented completion of dementia specific training for E31 (LPN) revealed that this required training was completed on 9/18/19 - after this information was requested by the surveyor (on 9/17/19 at 10:30 am). E31 was hired on 4/3/14.</p> <p>9/19/19 10:00 AM - During an interview, E1 (NHA) confirmed that E31 completed the required training after it was requested by the surveyor.</p> <p>These findings were reviewed during the exit conference on 9/20/19 beginning at 10:15 AM with E1 (NHA), E2 (DON), E17 (Regional Nurse</p>	<p>A. No Residents were identified as a result this deficient practice. No correction needed.</p> <p>E31 completed the training on 9/18/19 after the information was requested.</p> <p>B. All residents have the potential to be affected, however none were identified.</p> <p>Staff Development will audit all nursing staff to identify any employee that is non complaint with the required Dementia Training. Training will be assigned to staff to complete prior to next work schedule.</p> <p>C. The root cause analysis was completed and determined that the PRN, E31, did not complete required training. E31 completed the training on 9/18/19 after the information was requested.</p> <p>Bi-annually, (January and July) all staff training will be reviewed by Human Resources Director or Designee to ensure employees are compliant with the required in-service training.</p> <p>Staff Development/Designee will in-service all staff and new hires on required trainings. This will be offered upon hire and then reviewed bi-annually for compliance.</p>	11/11/19

Provider's Signature  Title NHA Date 10/18/19  
NHA Revised 11/4/19



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**STATE SURVEY REPORT**

NAME OF FACILITY: Atlantic Shores Rehabilitation & Health Center DATE SURVEY COMPLETED: September 20, 2019

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
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<p>16 Del. C., 1162</p>	<p>Consultant) and E21 (Assistant NHA).</p> <p><b>Nursing Staffing:</b></p> <p>(a) Every residential health facility must at all times provide a staffing level adequate to meet the care needs of each resident, including those residents who have special needs due to dementia or a medical condition, illness or injury. Every residential health facility shall post, for each shift, the names and titles of the nursing services direct caregivers assigned to each floor, unit or wing and the nursing supervisor on duty. This information shall be conspicuously displayed in common areas of the facility, in no fewer number than the number of nursing stations.</p> <p>This requirement is not met as evidenced by:</p>	<p><b>3201.5.6</b></p> <p>D. Dementia Training compliance for all nursing staff will be audited monthly by Human Resources Director or designee until 100% compliance is achieved x 3 evaluations. Following will be a bi-annual audit <i>of all nursing staff</i> to ensure consistent compliance is sustained x 2 evaluations. In an event where continued non compliance is consistently below the goal, Interdisciplinary Team (IDT) will meet together with the QA Committee to review the process and revision will be made to maintain and sustain compliance. Monthly audit reports will be submitted to QA committee monthly for the next quarter.</p>	
	<p>Based on observation and interview, it was determined that the facility failed to conspicuously display the names and titles of the nursing staff direct caregivers assigned to each unit for four (Ocean Gardens, Seaside Way, Beach Cove and Bay Terrace) out of four units and failed to display the nursing supervisor on duty for each shift in the common areas of three (Seaside Way, Beach Cove and Bay Terrace) of the four nursing units.</p> <p>9/19/19 8:55 AM – An observation of the Ocean Gardens nursing unit revealed a large white board with staff assignments, but did not include the titles of the staff (e.g., CNA, RN or LPN) and did not include the names of the nurses on duty.</p> <p>9/19/19 8:59 AM – During an interview, E30 (LPN, UM) confirmed the above findings and stated the required information would be added to the white board.</p>	<p><b>16 Del. C., 1162</b></p> <p>A. No Residents were identified as a result this deficient practice. No correction is required.</p> <p>B. All residents have the potential to be affected, however none were identified. No correction is required.</p>	<p>11/11/19</p>

Provider's Signature

Title NHA

NHA

Date 10/18/19

Revised 11/4/19



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SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	<p>9/19/19 9:05 AM – An observation of the Bay Terrace nursing unit revealed a large white board with staff assignments, but did not include the titles of the staff (e.g., CNA, RN or LPN) or the names of the nurses and nursing supervisor on duty.</p> <p>9/19/19 9:06 AM – During an interview, E13 (RN, UM) confirmed the above findings and stated the required information would be added to the white board.</p> <p>9/19/19 9:10 AM – An observation of the Seaside Way nursing unit revealed a large white board with staff assignments, but did not include the titles of the staff (e.g., CNA, RN or LPN) or the names of the nurses and nursing supervisor on duty.</p>	<p>C. The root cause analysis was completed and determined that the facility did not consistently display the names and titles of the nursing direct caregivers assigned to each unit and the name of the Nursing Supervisor on duty.</p> <p>The facility white board posting will be revised to include direct caregivers names and titles on each unit. The Nursing Supervisor on duty's name will be included in the posting.</p> <p>Daily, Unit Managers/Designee will update the information at the beginning of the shift.</p>	
	<p>9/19/19 9:12 AM – During an interview, E21 (LPN, UM) confirmed the above findings and stated the required information would be added to the white board.</p> <p>9/19/19 9:18 AM – An observation of the Beach Cove nursing unit revealed a large white board with staff assignments, but did not include the titles of the staff (e.g., CNA, RN or LPN) or the names of the nurses and nursing supervisor on duty.</p> <p>9/19/19 9:20 AM – During an interview, E5 (LPN, UM) confirmed the above findings and stated the required information would be added to the white board.</p> <p>These findings were reviewed during the exit conference on 9/20/19 beginning at 10:15 AM with E1 (NHA), E2 (DON), E17 (Regional Nurse Consultant) and E21 (Assistant NHA).</p>	<p>D. Daily audits will be conducted by the Unit Managers/Designee to ensure staff posting is available on each unit and is compliant with the required staffing information until a 100% compliance is achieved x 7 consecutive evaluations. Following will be weekly audits to ensure consistently compliance of 100% is achieved x 4 evaluations, then monthly x 3 evaluations. In an event where continued non compliance is consistently below the goal, Interdisciplinary Team (IDT) will meet together with the QA Committee to review the process and revision will be made to maintain and sustain compliance. A monthly audit report will be submitted to QA committee</p>	

Provider's Signature

Title NHA

NHA

monthly for the next quarter.

10/18/19  
Revised 11/4/19