DELAWARE HEALTH AND SOCIAL SERVICES

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

DHSS - DHCQ
263 Chapman Road, Suite 200, Cambridge Bldg.
Newark, Delaware 19702
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: Atlantic Shores Rehabilitation

DATE SURVEY COMPLETED: July 18, 2024

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	POST IDR An unannounced Annual and Complaint Survey was conducted at this facility from July 9, 2024 through July 18, 2024. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documents as indicated. The facility census the first day of the survey was one hundred sixty-three (163). The survey sample totaled thirty-three (33) residents.	
3201		
3201.1.0	**Regulations for Skilled and Intermediate Care Nursing Facilities**	
3201.1.2	**Scope** **Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** This requirement is not met as evidenced by: Cross Refer to the CMS 2567-L survey completed July 18, 2024: cross refer: F550, F561, F582, F584, F602, F623, F625, F641, F644, F656, F657, F658, F676, F684, F690, F695, F710, F726, F745, F812, F842, F867, F880, and F921.	

Provider's Signature [signature] Title NHA Date 9/6/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085037	A. BUILDING _____ B. WING _____	C 07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLANTIC SHORES REHABILITATION & HEALTH CENTER	231 SOUTH WASHINGTON STREET MILLSBORO, DE 19966

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E 000	Initial Comments An unannounced Annual and Complaint survey was conducted at this facility from July 9, 2024 through July 18, 2024. The facility census was 163 on the first day of the survey. In accordance with 42 CFR 483.73, an Emergency Preparedness survey was also conducted by The Division of Health Care Quality, the Office of Long-Term Care Residents Protection at this facility during the same time period. Based on observations, interviews, and document review, no Emergency Preparedness deficiencies were identified.	E 000		
F 000	INITIAL COMMENTS POST IDR An unannounced Annual and Complaint Survey was conducted at this facility from July 9, 2024 through July 18, 2024. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documents as indicated. The facility census the first day of the survey was one hundred sixty-three (163). The survey sample totaled thirty-three (33) residents. Abbreviations/definitions used in this report are as follows: ADON - Assistant Director of Nursing; APS- Adult Protective Services: CNA - Certified Nursing Assistant; COTA - Certified Occupational Therapy Assistant; DON - Director of Nursing; EMR - electronic medical record; FM - Family Member; INR- international normalized ratio- a blood test	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 08/12/2024

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

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F 000	Continued From page 1 that indicates how well the blood is able to clot; IP - Infection Preventionist; LPN - Licensed practical nurse; MD - Medical Director; MDRO - multidrug resistant organism; NHA - Nursing Home Administrator; nonogram- in medicine, a pictorial representation of a complex mathematical formula; NP - Nurse Practitioner; PCC - Point click Care, the electronic medical record application that is utilized by the facility; PICC - peripherally inserted central catheter; PRN - as needed; QA - Quality Assurance; RN - Registered nurse; SW - Social Worker; UM - Unit Manager; ADLs - Activities of daily living - tasks needed for daily living, e.g. dressing, hygiene, eating, toileting, bathing; Adjustment disorder - group of symptoms such as stress, feeling sad or hopeless, having a hard time coping after a stressful life event; Altered mental status - most often refers to an abnormal change in your responsiveness and awareness; BIMS (Brief Interview for Mental Status) - test to measure thinking ability with score ranges from 00 to 15. 13-15: Cognitively intact, 08-12: Moderately impaired, 00-07: Severe impairment; Catheter - a small tube used for fluid to drain; Cerebral Infarction - Stroke in the brain; Cognitively Intact - able to make own decisions; Delusional disorder- A serious mental illness previously called paranoid disorder, in which a person can't tell real from what is imagined; Delusions - a belief held with strong conviction despite evidence to the contrary;	F 000		

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F 000	Continued From page 2 Dementia - a severe state of cognitive impairment characterized by memory loss, difficulty with abstract thinking, and disorientation; Dislodgement - to force out of a secure or settled position; EMR - (Electronic Medical Record) - a systematized collection of patient and population electronically stored health information in a digital format; Foley catheter - a tubular, flexible instrument inserted and retained in the bladder by a balloon to empty urine from the bladder; Hemiplegia - half of body paralyzed; Major Depressive Disorder - also known as depression, is a mental disorder characterized by at least two weeks of low mood that is present across most situations. Minimum Data Set (MDS) - standardized assessment forms used in nursing homes; Neurogenic bladder - a person lacks bladder control due to a brain, spinal cord, or nerve condition; Preadmission Screening and Resident Review (PASSAR) - screening for evidence of serious mental illness and/or intellectual disabilities, developmental disabilities or related conditions. to ensure that individuals are thoroughly evaluated and they are placed in nursing homes only when appropriate and that they receive all necessary services while they are there; Psychotic disorder(s) - severe mental disorders that cause abnormal thinking and perceptions; Tracheostomy - an opening made in the throat to assist breathing; Traumatic brain injury- A head injury causing damage to the brain by external force or mechanism. It causes long term complications or death; Urinary continence- ability to prevent accidental	F 000		

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F 000	Continued From page 3 leakage of urine from bladder Urinary incontinence- inability to prevent accidental leakage of urine from bladder	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 or resident of the United States. §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.	F 550		9/4/24

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F 550	Continued From page 4 §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review, it was determined that for one (R36) out of three residents reviewed for dignity, the facility failed to promote dignity by not using a privacy bag for a urinary collection bag. Findings include: A review of the facility's policy titled "Catheter Care" last revised 4/2024, documented ... "2. Privacy bags will be available and catheter drainage bags will be covered at all times while in use ...". Review of R36's clinical record revealed: 1/26/24 - R36 was admitted to the facility. 2/22/24 - A care plan documented that R36 has an indwelling catheter for neurogenic bladder. 4/3/24 - A physician's order for foley catheter to straight bag drainage for urinary retention. 7/9/24 - Observations of R36 lying in bed with the catheter collection bag was visible from the hallway and not in a privacy bag at 10:23 AM, 11:14 AM and 1:56 PM. 7/10/24 11:31 AM - An observation of R36's being pushed back to the room in a wheelchair where the catheter collection bag was not in a privacy	F 550	Privacy cover was provided to R36 Residents with foley catheters are potentially affected. Root cause analysis determined that staff did not provide privacy cover for urinary collection bag. Nursing staff will be educated regarding the need to provide privacy covers to urinary collection bags. Physician orders will be written for each resident with a foley catheter for a privacy cover to be documented each shift, including tasks in the electronic medical record and on the kardex. Audits will be completed weekly for four weeks and then monthly for three months to verify that residents with catheter collection bags have a privacy cover. Results will be reported to the QAPI Committee monthly.	

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F 550	Continued From page 5 bag and hooked onto the wheelchair. An interview with E15 stated she brought R36 back from the large therapy room located off R36's unit and located near the main facility entrance. E15 confirmed that the catheter collection bag did not have a privacy cover and immediately got a privacy bag and covered the catheter collection bag. 7/18/24 1:05 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (QA/IP), E4 (Corporate RN) and E7 (ADON) at the exit conference.	F 550		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility.	F 561		9/4/24

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F 561	Continued From page 6 §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined that for one (R143) out of thirty-three residents reviewed in the investigative sample, the facility failed to ensure care preferences were being honored. Findings include: Review of R143's clinical record revealed: 4/4/24 - R143 was admitted to the facility. 4/6/24 - An admission MDS revealed that R143 was not assessed for shower or bathing preferences. 4/10/24 - An admission recreation assessment revealed that for R143 it was very important to choose between a tub bath, shower, bed bath or sponge bath. 7/9/24 - R143 was readmitted from hospital. 7/9/24 12:31 PM - A physician's order revealed shower days were Wednesday and Saturday on the 3 -11 shift with skin check on Saturday and to document refusals every Wednesday and Saturday. 7/10/24 12:58 PM - An interview with R143 revealed that the facility did not give R143 a choice of shower day or time. R143 stated that she prefers showers in the morning.	F 561	R143 was interviewed by Unit Manager for her shower time preference. Shower was scheduled accordingly. Residents who take showers are potentially affected. Root Cause Analysis determined a lack of understanding on the importance of resident preferences for showers being discussed with residents and communicated to the Nursing staff. Interviews of residents who take showers will be conducted to verify that shower times/day coincide with preferences. After the initial preference assessment is completed, Activities staff will inform the Nursing staff of the resident preference for shower time/day during the admission review at morning meeting. On completion of the initial MDS, Assessment Coordinator will verify that the shower time specified in the EMR corresponds with the preferences entered on the MDS. Discrepancies will be brought to the attention of the Unit Manager at the daily clinical meeting for correction. Audit will be conducted daily at clinical review of admissions to verify that shower time preferences are scheduled for each	

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F 561	Continued From page 7 7/17/24 11:00 AM - An interview with E12 (Activities Assistant Director) revealed that the initial recreation assessment is completed upon admission and is shared with the MDS coordinator and nursing to help establish what's important to the resident. 7/17/24 11:15 AM - An interview with E11 (LPN) revealed that shower schedule is based on room assignment. 7/17/24 11:20 AM - An interview with E10 (LPN UM) confirmed that shower scheduled is based on room assignment for day and time. 7/18/24 1:05 PM - Findings were reviewed with E1 (NHA) , E2 (DON), E3 (QA/IP), E4 (Corporate RN) and E7 (ADON) at the exit conference.	F 561	resident. The audits will be ongoing as they will be incorporated in the review with all required admission documentation. Results will be reported to QAPI monthly.	
F 563 SS=D	Right to Receive/Deny Visitors CFR(s): 483.10(f)(4)(ii)-(v) §483.10(f)(4) The resident has a right to receive visitors of his or her choosing at the time of his or her choosing, subject to the resident's right to deny visitation when applicable, and in a manner that does not impose on the rights of another resident. (ii) The facility must provide immediate access to a resident by immediate family and other relatives of the resident, subject to the resident's right to deny or withdraw consent at any time; (iii) The facility must provide immediate access to a resident by others who are visiting with the consent of the resident, subject to reasonable clinical and safety restrictions and the resident's right to deny or withdraw consent at any time; (iv) The facility must provide reasonable access to a resident by any entity or individual that	F 563		9/4/24

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F 563	Continued From page 8 provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time; and (v) The facility must have written policies and procedures regarding the visitation rights of residents, including those setting forth any clinically necessary or reasonable restriction or limitation or safety restriction or limitation, when such limitations may apply consistent with the requirements of this subpart, that the facility may need to place on such rights and the reasons for the clinical or safety restriction or limitation. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R146) out of three residents reviewed for abuse, the facility failed to have written policies and procedures regarding the visitation rights of residents with cognitive impairments that do not have a legal decision maker. Findings include: Cross refer F602, F609 and F745. Review of R146's clinical record revealed: 3/30/24 - R146 was admitted to the facility with diagnoses, including but not limited to altered mental status. 4/2/24 2:59 PM - E5 (Social Work Director) documented in R146's EMR. " ...[R146] scored 3/15 on her BIMS assessment which indicates that she has severe cognitive deficit ...". 4/5/24 - R146's admission MDS assessment documented a BIMS score of three, which reflected severe cognitive impairment.	F 563	R146 is no longer going on social Leaves of Absence pending outcome of the guardianship hearing. Residents who have a BIMS score <8 and who have no legal decision maker are potentially affected. Root cause analysis determined that the Center lacked a policy re: social LOAs. LOA policy was developed and implemented. Admissions, Social Service, Business Office and Nursing staff will be educated re: the policy. Audits will be conducted by NHA or designee of LOAs to determine that the LOAs are conducted in compliance with the policy: physician order for social LOA in place, contact information of person accepting responsibility provided, notification and designated representative, weekly for four weeks or until 100% compliance is achieved for two consecutive weeks, then monthly for three	

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F 563	Continued From page 9 5/29/24 - E46 (Psychologist) documented in R146's EMR, "Her judgment and insight are impaired. At this time, patient is not capable of making her own healthcare decisions." 5/31/24 - The facility made a referral for capacity determination. 6/3/24 - E39 (MD) documented in a Physician Affidavit for Guardianship that R146 did not have capacity to function independently including: activities of daily living, pay her own bills, live alone, take medicine appropriately, give consent for medical procedures and resist scams. 6/3/24 10:06 AM - F4 (male friend) signed R146 out of the facility in the Leave of Absence log. R146 was signed back into the facility at 11:35 AM. 6/4/24- The facility petitioned the Court of Chancery to initiate R146's guardianship process. According to the Release of Responsibility for Leave of Absence log, R146 was signed out and left the facility on a leave of absence with unrelated persons on 5/20/24, 5/25/24, 6/3/24, 6/21/24, 6/28/24 and 7/12/24. 7/10/24 3:20 PM - A review of R146's face sheet revealed that R146 listed as "responsible party" and F2 (R146's sister) listed as emergency contact #1 and F3 (R146's other sister) listed as emergency contact #2. The facility failed to ensure that R146, a resident with severe cognitive impairment, did not leave the facility without her family's consent.	F 563	months to verify compliance is maintained.	

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F 563	Continued From page 10 7/12/24 3:13 PM - During an interview, E1 (NHA) stated, "We don't have a policy or procedure for residents that have been deemed not to have capacity and don't have a legal guardian or POA (power of attorney)." 7/15/24 12:29 PM - During an interview, E38 (NP) stated, "There are no special orders that we place when a patient is deemed not to have capacity..." 7/16/24 10:10 AM - During an interview, E5 (SW) stated, "To my knowledge, there is no policy or precedent regarding when a resident is deemed not to have capacity. I am not aware of any restrictions regarding leaving the facility. I guess you would call her sister. I am not aware of a guardian ad litem." 7/18/24 1:05 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (QA/IP), E4 (Corporate RN) and E7 (ADON) at the exit conference.	F 563		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services	F 582		9/4/24

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F 582	Continued From page 11 specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was	F 582	The emergency contact of R146 was	

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	085037	A. BUILDING _____ B. WING _____	C 07/18/2024

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F 582	Continued From page 12 determined that for one (R146) out of three residents reviewed for beneficiary notice, the facility failed to provide notification of service changes to R146's authorized representative. Findings include: Review of R146's clinical record revealed: 3/30/24 - R146 was admitted to the facility. 4/5/24 - R146's admission MDS assessment documented a BIMS score of three, which reflected severe cognitive impairment. 4/12/24 - R146 given a Notice of Medicare Non-Coverage (NOMNC) that advised that R146's effective date of last day of Medicare coverage was 4/17/24. The document was signed by E44 (Social Work) and E43 (Business Office manager) with the statement "unable to sign BIM of 3" written in box beneath the statement "Signing below means that you've received and understand this notice ...". 7/9/24 1:54 PM - During a telephone interview, F2 (R146's sister) stated that she was not informed about R146's last day of Medicare coverage and was not offered the opportunity to appeal. 7/10/24 3:20 PM - A review of R146's face sheet revealed that R146 listed as "responsible party" and F2 (R146's sister) listed as emergency contact #1 and F3 (R146's other sister) listed as emergency contact #2. The facility was unable to provide evidence of any attempt to reach either emergency contact for the purpose of receiving the NOMNC notification.	F 582	notified of the service changes. Residents with BIMS scores < 8 who have a service change are potentially affected. An audit of the residents with service changes in the last three months was conducted to ensure that representatives or emergency contacts of residents with BIMS < 8 were notified. Root cause analysis determined that the notice provider failed to understand the notification requirements. Social workers and Business Office Manager were educated regarding the notification requirements for service changes. Service changes will be audited by NHA or designee weekly for 4 weeks and monthly for 3 months. Results will be reported to QAPI Committee meeting monthly.	

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F 582	Continued From page 13 7/18/24 1:05 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (QA/IP), E4 (Corporate RN) and E7 (ADON) at the exit conference.	F 582		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas;	F 584		9/4/24

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F 584	Continued From page 14 §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that for one out of five resident units, the facility failed to provide a clean and homelike environment. Findings include: 7/9/24 10:13 AM - An observation in the 300 hallway of Ocean Gardens unit, revealed a broken handrail with jagged edges not covered. The baseboards in 400 hallway were dirty and dusty, and an area where a dark substance was spilled on wall with a stain. Subsequently the same observation occurred on 7/10/24 and 7/11/24. 7/12/23 1:00 PM - An interview with E13 (Maintenance Director) revealed that the facility has a plan to replace all handrails with new design. E13 stated he will cover the broken handrail for safety concerns for the current time until new rails are installed. E13 also stated that maintenance will clean the base boards and wall of the 400 hallway. 7/15/24 9:51 AM - An observation of a handrail in the 300 hallway of Ocean Gardens unit, revealed a broken handrail with jagged edges not covered. The baseboards in 400 hallway were dirty and dusty, and an area where a dark substance was spilled on wall with a stain.	F 584	Hand rail repaired. Baseboards and wall were cleaned. Audit was conducted of the Nursing units to verify that handrails are in good repair and that hallway walls and baseboards are clean. No residents were identified. The four Nursing units are potentially affected. The Maintenance Director/Designee will re-educate maintenance and housekeeping department to ensure a clean and homelike environment. A request for repair will be entered in REQQER system to ensure timely follow-up. Audits of handrail safety and hallway cleanliness will be conducted weekly by NHA or designee for four weeks until 100% compliance is achieved for two consecutive weeks and then monthly for 3 months. Results will be reported to QAPI Committee monthly.	

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F 584	Continued From page 15 7/15/24 2:17 PM - An interview with E13 confirmed the handrail should have been fixed over the weekend and it will get taken care of today. Also noted the walls and base boards will be cleaned today. 7/18/24 1:05 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (QA/IP), E4 (Corporate RN) and E7 (ADON) at the exit conference.	F 584		
F 602 SS=D	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R146) out of three residents reviewed for abuse, the facility failed to protect R146 from misappropriation of resident property/funds. Findings include: Review of R146's clinical record revealed: 3/30/24 - R146 was admitted to the facility. 4/5/24 - R146's admission Minimum Data Set (MDS) assessment documented R146's BIMS score of three, which reflected severe cognitive impairment. 4/12/24 - A Notice of Medicare Non-Coverage	F 602	R146 allegation of missing funds was reported to DHSS on 7/15/24. Residents with BIMS <8 have the potential to be affected. Sweep will be conducted of the residents with BIMS <8 who have no legal representative. BOM, AD, SSD and NHA will determine risk level based on identified key factors. NHA, DON, ADON, SSD, Social Workers, BOM and AD were educated regarding reporting of reasonable suspicion of crime and allegations of abuse by Attorney General office.	9/4/24

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F 602	Continued From page 16 (NOMNC) documented that R146's last day of Medicare coverage was 4/17/24. The document was signed by E44 (Social Worker) and E43 (Business Office manager) with the statement "unable to sign BIM of 3" written in box beneath the statement "Signing below means that you've received and understand this notice ...". 5/16/24 - According to a signed and dated statement, F2 (R146's sister) provided the facility with R146's identification, bank statement, other documents and R146's checkbook. F2 had E1 (NHA) and E5 (SW Director) sign the document listing all the documents and belongings that F2 handed over to the facility. 5/17/24 11:05 AM - E43 (Business Office manager) documented a note in R146's EMR that stated R146's checkbook and other documents were secured in the facility safe. 5/19/24 3:43 PM - E45 (RN) documented in R146's EMR that a family member called and requested that R146 should not sign anything without her family present. 5/23/24 - E1 (NHA) and E43 (Business Office manager) obtained R146's checkbook from the facility safe and assisted R146 to write two checks- Check #4483 to the facility in the amount of $6435 for "April room/Board" and another check as deposit for an assisted living facility that R146 was interested in transferring to. The facility failed to identify that R146 was not cognitively capable of understanding a financial transaction and failed to safeguard R146's property from inappropriate access.	F 602	Facility will identify residents and will report to DHSS residents with BIMS <8 who are not capable of understanding a financial transaction and inappropriate access was obtained in the last 30 days. Root cause analysis was determined to be lack of oversight in protecting cognitively impaired residents from potential misappropriation of property/funds. On admission, residents with BIMS <8 with no legal representative will be assessed according to the key identifiers for potential of misappropriation or exploitation. For those residents determined to be at risk from potential inappropriate access, a report will be made to DHSS and APS. Audits will be conducted by NHA or designee weekly for 4 weeks or until 100% compliance is achieved for 2 consecutive weeks of a random sample of 50% of residents with BIMS <8 and no legal representative to determine that any potential risk of exploitation or misappropriation is identified and reported. Audits will then be conducted monthly of 25% of residents who meet this criteria for 4 months to ensure continued compliance. Results will be reported to QAPI Committee monthly.	

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F 602	Continued From page 17 5/29/24 - E46 (Psychologist) documented in R146's EMR, "Her judgment and insight are impaired. At this time, pt is not capable of making her own healthcare decisions." 5/31/24 - E43 received an email from the facility Home Office stating that check #4483 was returned for insufficient funds. 5/31/24 - The facility made a referral for capacity determination. 6/3/24 - E39 (MD) completed a Physician Affidavit for Guardianship which documented that R146 does not have capacity. 7/12/24 9:31 AM - During an interview, E44 (SWS) stated, "When I was explaining about the insurance, she did not understand. She did not understand what she was signing so she did not sign. She would nod her head in agreement but she did not understand." 7/12/24 9:55 AM - During an interview, E43 stated, "Only the NHA and I have access to the safe. The NHA and I took her checkbook to her to write the checks (to [assisted living facility] and to us). That is when we found out the money was gone because the checks bounced ... I told the NHA and Social worker was to report it to APS (Adult Protective Services)." The facility was unable to provide evidence that this allegation of missing resident funds was reported to the State agency. 7/18/24 1:05 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (QA/IP), E4 (Corporate RN) and E7 (ADON) at the exit conference.	F 602		

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F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or	F 623		9/4/24

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F 623	Continued From page 19 (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice.	F 623		

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F 623	Continued From page 20 If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R130) out of ten residents reviewed for hospitalization, the facility failed to notify R130's family representative and the Ombudsman of R130's transfers to the hospital on 3/15/24 and 3/24/24. Findings include: 10/26/23 - R130 was admitted to the facility's locked dementia unit with diagnoses, including: dementia with agitation. 1/31/24 - R130's quarterly MDS documented a BIMS score as five, which reflected severe cognitive impairment. 3/15/24 - R130 was transferred to the hospital for three episodes of coffee-ground emesis and was diagnosed with a gastrointestinal bleed. R130 returned to the facility on 3/17/24. 3/25/24 - R130 was transferred to the hospital for	F 623	Emergency contact of R130 was notified of the transfers to the hospital on 3/15 at 1830 and 24 at 0000 as documented on the SBAR. Ombudsman report for March 2024 was amended to include the two transfers for R130. Residents sent to hospital have the potential to be affected. Audit of medical records of residents hospitalized in the last three months were conducted to verify that resident representative or emergency contact was notified. Reports sent to ombudsman for last three months were reviewed for accuracy. Social Service staff was educated re: content of report to ombudsman.	

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F 623	Continued From page 21 a syncopal episode. R130 returned to the facility on 3/27/24. 7/17/24- Review of R130's EMR revealed F1 (R130's son) was listed as "Emergency contact # 1" and R130 was listed as "responsible party". 7/17/24 - Review of R130's Transfer Notices, dated 3/15/24 and 3/25/24, both revealed R130 listed as the responsible party to whom the notice was presented. In both instances, the facility failed to notify an appropriate resident representative of R130's transfers to the hospital. R130 had a documented and known severe cognitive impairment. 7/17/24 - Review of the March 2024, Ombudsman Admission/ Discharge Notice revealed that R130's name was not listed on the report at any point throughout the month of March 2024 as a transfer to an acute care hospital. Neither transfer (3/15/24 or 3/25/24) was listed on the Ombudsman notification for March 2024. The facility failed to provide the Office of the Ombudsman notification of R130's 3/15/24 and 3/25/24 transfers to an acute care hospital. 7/18/24 1:05 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (QA/IP), E4 (Corporate RN) and E7 (ADON) at the exit conference.	F 623	Audits will be conducted by NHA or designee monthly for three months to verify that ombudsman report is inclusive.	
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a	F 625		9/4/24

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F 625	Continued From page 22 nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R130) out of ten residents reviewed for hospitalization, the facility failed to notify the family representative of the bed-hold policy. Findings include: Review of R130's clinical record revealed: 10/26/23 - R130 was admitted to the facility's locked dementia unit with diagnoses including: dementia with agitation.	F 625	The emergency contact ofcR130 was provided a copy of the bed hold policy by Social Service Director. Residents transferred to the hospital are potentially affected. Audit of residents transferred to hospital in the last three months was conducted to verify that representatives or emergency contacts of residents with BIMS <8 were provided with bed hold policy on hospital transfer. Root cause analysis determined that the	

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	085037	A. BUILDING _____ B. WING _____	C 07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 625	Continued From page 23 1/31/24 - R130's quarterly MDS documented a BIMS score of five, which reflected severe cognitive impairment. 3/15/24 - R130 was transferred to the hospital for three episodes of coffee-ground emesis (vomit) and was diagnosed with a gastrointestinal bleed. R130 returned to the facility on 3/17/24. 3/25/24 - R130 was transferred to the hospital for a syncopal (fainting) episode. R130 returned to the facility on 3/27/24. 7/17/24 - Review of R130's EMR revealed F1 (R130's son) was listed as "Emergency contact # 1" and R130 was listed as "responsible party". 7/17/24 - Review of R130's Bed-hold Policy Notices, dated 3/15/24 and 3/25/24, both revealed R130 listed as the responsible party to whom the notice was presented. The facility failed to notify an appropriate resident representative of the facility's bed-hold policy for R130's hospitalizations. 7/18/24 1:05 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (QA/IP), E4 (Corporate RN) and E7 (ADON) at the exit conference.	F 625	bed hold policy was not provided to the emergency contact because R130 is listed as her own Representative. Procedure has been changed to provide bed hold policy to representative or emergency contact. Social Service, Admissions and Business Office staff have been educated regarding this procedural change. Audits will be completed weekly x 4 weeks or until 100% compliance is achieved for two consecutive months, by the NHA or designee to determine that a resident representative or emergency contact was notified of the bed hold policy on transfer to hospital. Audits will then be conducted monthly for three months to verify lasting compliance. Results will be reported to the QAPI committee.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was	F 641	MDS of resident R66 and R146 were	9/4/24

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F 641	Continued From page 24 determined that for three (R66 and R146) out of thirty-three residents reviewed in the investigative sample, the facility failed to ensure an accurate assessment. Findings include: 1 Review of R66's clinical record revealed: 5/10/18 - R66 was admitted to the facility. 2/17/24 - Section I of the annual MDS revealed the following: "No natural teeth or tooth fragment(s) (edentulous): Yes." Obvious or likely cavity or broken natural teeth was not checked. 7/11/24 11:45 AM - In an interview, E20 (CNA) and E21 (CNA) revealed R66 does not complain of pain with eating and does not wear dentures. 7/11/24 11:50 AM - In an interview, it was revealed that R66 does not have dentures. The surveyor noted that R66 has teeth, but they are in disrepair. R66 stated that although dental exams are offered, R66 declines to attend. 7/12/24 3:35 PM - In an interview, E19 (MDS Coordinator) confirmed that the MDS reflected that resident is edentulous (lack of teeth). Surveyor advised that R66 has broken teeth and R66 confirmed she does not have dentures. 2. Review of R146's clinical record revealed: 3/30/24 - R146 was admitted to the facility. 4/5/24 - R146's admission MDS assessment documented a BIMS score of three, which reflected severe cognitive impairment. 5/8/24 - E38 (NP) ordered a "wander guard check	F 641	corrected. Residents for whom MDS assessments are completed have the potential to be affected. Root cause analysis determined that re-education re: MDS coding was required. Education provided to MDS staff re: proper coding and sources of information for Section L (Oral/Dental Status) and wander/elopement alarm status. Audits will be conducted by RNAC of current residents' most recent MDS completed to determine that Oral/Dental Status and placement of wander/elopement alarm is accurately coded on the assessment. Random audits will be completed on the MDS forms of 20% of residents for accuracy of Oral Dental Status and wander/elopement alarm status weekly x 4 weeks or until 100% compliance is achieved for four consecutive weeks, and then monthly x 3 months to verify continued compliance. Results will be reported to the QAPI Committee.	

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F 641	Continued From page 25 placement every shift." 7/3/24 - R146's quarterly MDS documented that R146 did not have a wander/elopement alarm. 7/12/24 9:32 AM - During an interview, E42 (CNA) confirmed that R146 still had a wander guard alarm on her person. 7/12/24 3:42 PM - During an interview, E19 (RNAC) confirmed that R146's 7/3/24 quarterly MDS was modified "yesterday" to include that R146 did in fact have a wander guard alarm. 7/18/24 1:05 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (QA/IP), E4 (Corporate RN) and E7 (ADON) at the exit conference.	F 641		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon	F 644		9/11/24

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F 644	Continued From page 26 a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that for three (R14, R37 and R98) out of three residents reviewed for PASARR, the facility failed to ensure that a referral for a PASARR screening was completed. Findings include: A review of the facility's policy titled "Resident Assessment - Coordination with PASARR Program" last revised 6/18/24, documented ... "9. A resident who exhibits a newly evident or possible serious mental disorder, intellectual disability, or related condition will be referred promptly to the state mental health or intellectual disability authority for a level II resident review." 1. Review of R14's clinical record revealed: 5/9/21 - R14 had a level I PASARR completed. 6/7/21 - R14 was admitted to the facility with the following diagnoses: major depressive disorder, adjustment disorder with depressed mood, and delusional disorder. 5/31/23 - R14 was diagnosed with the following diagnoses: unspecified dementia with agitation, violent behavior, and moderate major depressive disorder. 7/16/24 09:52 AM - An interview with E5 (SW Director) confirmed that R14 did not have a level II PASARR completed and one was needed. 2. Review of R37's clinical record revealed:	F 644	Referrals were made for PASARR screenings for R14, R37 and R98. All residents are potentially affected. Root cause analysis determined that turnover in the Social Service Department created a lack of follow-through on obtaining second level PASARR screenings on a timely basis. Medical records of current residents were reviewed to ensure that PASARRs are timely and correct. Social Service and Admissions staff were trained on July 16, 2024 by the PASARR unit regarding PASARR completion and timing. Audits will be conducted by Admission Director or designee on a random sample of 20% of residents weekly for four weeks and then monthly for three months to verify that PASARRs are accurate and timely. Results will be reported to the QAPI Committee monthly. Attempt made to correct spacing.	

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F 644	Continued From page 27 11/4/18 - R37 was admitted to the facility. 11/5/18 - A level I PASARR was completed and revealed " ... this patient appears to have: Indicators of mental illness, mental retardation/related conditions, but meets physician's exemption criterion ...". 12/20/18 - A level 1.5 PASARR was completed and revealed "The individual does have a documented serious mental illness (SMI) or a mental illness other than SMI but further review of level of impairment, recent treatment history, or other circumstances demonstrates a full level II is not required ...". 5/12/23 - Unspecified mood (affective) disorder and unspecified dementia, unspecified severity, without behavioral disturbance psychotic disturbance, mood disturbance and anxiety were added to R37's list of diagnoses. 7/11/24 2:28 PM - In an interview, E1 (NHA) confirmed that given the transition with social workers, there were issues with PASARR's not being completed. E1 stated this situation is being audited and this has been ongoing since May. 7/11/24 - A request for a Level II PASARR was completed by E5 (SW Director). 7/16/24 - A Notice of a PASARR Level I Screen Outcome was received from Maximus confirming that a Level II Onsite PASARR was needed. 3. Review of R98's clinical record revealed: 12/4/20 - R98 had a level I PASARR completed at the hospital with the indication of no level II	F 644		

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F 644	Continued From page 28 needed and no suspected or confirmed PASARR conditions. 2/2/21 - R98 was admitted to the facility with diagnoses including cerebral infarction and altered mental status. 4/5/21 - R98 had a level I PASARR completed with the indication of no level II needed and no suspected or confirmed PASARR conditions. 2/2/23 - The electronic medical record documented a new diagnoses of unspecified mild dementia with psychotic disturbance and psychotic disorder with delusions were identified. 6/19/23 - The electronic medical record documented a new diagnoses of unspecified dementia with agitation and violent behavior were identified. 6/20/23 - R98 had psychiatry visits on 6/20/23, 7/5/23, 7/11/23, 1/10/24 and 3/6/24. 7/16/24 9:52 AM - During an interview E5 (SW Director) stated the psych nurse practitioner will screen residents weekly and notify him, the unit manager, or the DON if a resident has any behavioral changes. E5 stated once notified, they will initiate a PASARR review. E5 stated that the facility was without a psych nurse practitioner who had a definitive schedule for a long time and some residents got missed. 7/16/23 12:15 - E5 confirmed a Level II PASARR was not submitted for R98 and one should have been submitted for review. 7/18/24 1:05 PM - Findings were reviewed with	F 644		

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F 644	Continued From page 29 E1 (NHA), E2 (DON), E3 (QA/IP), E4 (Corporate RN) and E7 (ADON) at the exit conference.	F 644		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the	F 656		9/11/24

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F 656	Continued From page 30 community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that for four (R123, R143, R146 and R109) out of thirty-three residents in the investigative sample the facility failed to develop and implement a comprehensive resident centered care plan for an identified care area. Findings include: 1. Review of R123's clinical record revealed: 2/15/24 - R123 was admitted to the facility. 2/21/24 - An admission MDS assessment revealed that R123 was always continent of bowel and bladder. The MDS revealed that R123 was not indicated for a toileting program at this time. 5/21/24 - A quarterly MDS assessment revealed that R123 was frequently incontinent of bowel and bladder. The MDS revealed that R123 was not indicated for a toileting program at this time. 7/11/24 9:31 AM - A review of R123's care plan revealed the facility lacked evidence of an incontinence care plan.	F 656	R109 no longer resides in the facility; unable to correct for this resident. The care plans of R123 and R143 were revised by ADON to include incontinence. The care plan of R146 was revised by SSD to include cognitive impairment. Audits were completed on the care plans of current residents to identify those who were lacking incontinence, cognitive impairment and anticoagulants. These care plans were put into place appropriately. Root cause analysis determined that some care plan items were omitted in error. Nursing Administration will provide direct oversight to ensure that appropriate care plans for incontinence, cognitive impairment and anticoagulants are in place. staff Development/Designee will educate licensed nurse, social services, and new hires to ensure care plans are in place for residents with incontinence, cognitive impairment, and on anticoagulant therapy. Audits will be completed weekly for four	

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F 656	Continued From page 31 7/15/24 10:29 AM - An interview with E27 (LPN UM) confirmed that R123 did not have a care plan for incontinence. 2. Review of 143's clinical record revealed: 4/4/24 - R143 was admitted to the facility. 4/6/24 - An admission MDS assessment revealed that R143 was occasionally incontinent of bowel and bladder. The MDS revealed that R143 was not indicated for a toileting program at this time. 7/11/24 9:42 AM - A review of R143's care plan revealed the facility lacked evidence of an incontinence care plan. 7/15/24 10:29 AM - An interview with E27 (LPN UM) confirmed that R143 did not have a care plan for incontinence. 3. Review of R146's clinical record revealed: 3/30/24 - R146 was admitted to the facility. 4/5/24 - R146's admission MDS assessment documented a BIMS score of three, which reflected severe cognitive impairment. 7/15/24 9:45 AM - A review of R146's care plans revealed the facility lacked evidence of a cognitive impairment care plan with interventions. 7/15/24 1:35 PM - During an interview, E3 (QA/IP) confirmed the lack of care plan interventions with regard to R146's cognitive impairment.	F 656	weeks, then monthly until 100% compliance is maintained for three months. Results will be submitted to QAPI Committee monthly.	

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F 656	Continued From page 32 4. Review of R109's clinical record revealed: 6/14/24 - R109 was admitted to the facility with diagnoses, including but not limited to, atrial fibrillation (Afib), deep vein thrombosis (DVT) and factor V Leiden heterozygous mutation, an inherited disorder that causes abnormal blood clots in legs or lungs. 7/11/24 10:45 AM - A review of R109's care plan revealed no evidence of a care plan or interventions regarding R109's need for anti-coagulation therapy due to the diagnoses of Afib and DVT. 7/15/24 1:35 PM - During an interview, E3 (QA/IP) confirmed the lack of care plan interventions with regard to R109's need for anti-coagulation therapy. 7/18/24 1:05 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (QA/IP), E4 (Corporate RN), and E7 (ADON) at the exit conference.	F 656		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident.	F 657		9/4/24

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F 657	Continued From page 33 (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for six (R25, R37, R47, R66, R68, and R75) out of thirty-three sampled residents for care plan investigations, the facility failed to ensure that the required interdisciplinary team (IDT) memebers participated in the care plan meetings and for R66's care plan inaccurately includes dentures. Findings include: A facility policy entitled "Comprehensive Care Plans" (revised 4/24) states, "The comprehensive care plan will be prepared by the interdisciplinary team, that includes, but is not limited to: a. The attending physician or non-physician practitioner designee involved in the resident's care, if the physician is unable to participate in the development of the care plan. B. A registered nurse with responsible for the resident. c. A nurse aide with responsibility for the resident. d. a member of the food and nutrition staff ... The comprehensive care plan will be reviewed and	F 657	Care plan meetings for R25, R75 and R37 cannot be corrected. Care plan for R66 was updated by ADON on 7/22/2024 and includes interventions for broken teeth. Care plan for R66 was updated on 7/17/2024 by Staff Development RN to include correct tracheostomy size and emergency procedures. Care plan for R68's refusal of showers was added by ADON. Documentation was placed in the medical records of R 25, R37, R47, R66, R68 and R75 that the physician, dietitian, and CNA input was considered and reviewed with resident and/or representative as part of the care plan. Current residents have the potential to be affected. Root cause analysis determined that turnover in the Social Worker and Dietitian positions and the need for using	

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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 657	Continued From page 34 revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment." 1. Review of R25's clinical record revealed: 9/21/23 - R25 was admitted to the facility. 9/25/23 - A baseline care plan was e-signed. 7/12/24 - E1 (NHA) provided a copy of a quarterly care plan meeting for 4/23/24 that lacked evidence of input from the Physician, a registered nurse with responsibility for the resident, a nurse aide with responsibility for the resident, and a food/nutrition services staff. Additionally, the facility lacked evidence that R25 had a quarterly care plan meeting in December, 2023. 2. Review of 37's clinical record revealed: 11/4/18 - R37 was admitted to the facility. 7/12/24 approximately 11:00 AM - E1 (NHA) provided a copy of a Comprehensive Resident Centered Care Plan Conference sheet for a quarterly meeting, which was undated. The facility lacked evidence that the attending physician, a registered nurse with responsibility for the resident, a nurse aide with responsibility for the resident and a member of food and nutrition services staff provided input. The surveyor also requested documentation for the three previous care plan meetings including the two quarterly meetings and the annual meeting, but the facility was not able to produce evidence that these meetings occurred. 3. Review of R66's clinical record revealed:	F 657	agency nursing staff caused inconsistency in the IDT. Care plans will be reviewed and revised by the IDT after each comprehensive and quarterly MDS assessment and documentation will identify attendance and input of IDT members. Staff Development/Designee will educate interdisciplinary team/IDT and new hires regarding participation of each discipline during care plan review. Audits will be completed by Social Service Director or designee weekly for four weeks or until 100% compliance is achieved for two consecutive weeks and then monthly for three months to verify that required disciplines are participating in the care plan review and revision. Results will be reported to the QAPI Committee monthly.	

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F 657	Continued From page 35 5/10/18 - R66 was admitted to the facility. 7/16/24 untimed - E1 (NHA) provided the surveyor with a Comprehensive Resident Centered Care Plan Conference Sheet for R66's annual care plan meeting on 8/28/23, which lacked evidence of input from the Physician, a nurse aide with responsibility for the resident, and a food/nutrition services staff. The facility lacked evidence that a quarterly care plan meeting was held in November, 2023, February, 2024 or May, 2024. Additionally, R66's care plan inaccurately reflected that R66 has an upper and lower dentures. 7/17/24 2:02 PM - In an interview, E14 (staff educator/acting UM) confirmed that R66's care plan inaccurately reflects that this resident had upper and lower dentures. E14 confirmed that resident has broken teeth but does not use dentures. 4. Review of R75's clinical record revealed: 10/9/18 - R75 was admitted to the facility. 7/15/24 approximately 9:45 AM - E1 (NHA) provided the surveyor with a Comprehensive Resident Centered Care Plan Conference Sheet for an annual care plan meeting on 10/26/23 that lacked evidence of from the Physician, a nurse aide with responsibility for the resident, and a food/nutrition services staff. The quarterly care plan meeting sheet also lacked evidence of input from these three IDT members. Additionally, the facility lacked evidence that R75 had a care plan meeting in August, 2023 or January, 2024. 5. Review of R47's clinical record revealed:	F 657		

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F 657	Continued From page 36 5/27/16 - R47 was admitted to the facility with the following but not limited to diagnoses traumatic brain injury and tracheostomy status. 5/29/16 - A review of a careplan for R47's impaired breathing mechanic's last updated 7/25/23 revealed that if R47's tracheostomy dislodges to complete the following interventions: 1. notify supervisor 2. call physician and 911 3. Assess respiratory status, if oxygen saturation is below ninety- two percent apply oxygen by ambu bag or by holding oxygen to the stoma site 4. liscense nurse may reattempt to resinsert trach as per policy. 6/1/16 - An admission MDS revealed that R47 required the following respiratory treatments oxygen, suctioning, and tracheostomy care. 5/22/24 - An annual MDS revealed that R47 required tracheostomy care. 7/15/24 10:29 AM- An interview with E27 (LPN UM) confirmed the care plan did not reflect the current needs related to R47's tracheostomy. The care plan did not reflect R47's current tracheostomy size or current emergency needs if tracheostomy dislodges. 6. Review of R68's clinical record revealed: 11/19/21 - R68 was admitted to the facility. 8/16/23 - A care plan revealed that R68 is resistive and non-compliant with treatment and care related to dementia. The interventions included allow flexibility in ADL routine and if resists care to reapproach.	F 657		

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F 657	Continued From page 37 7/18/24 9:50 AM - An interview with E31 (RN UM) revealed R68 only refuses showers and the following interventions are used: to call daughter, change times, change staff, and change approach. E31 confirmed the current interventions are not reflected on the careplan. 7/18/24 1:05 PM - Findings were reviewed with E1 (NHA) , E2 (DON), E3 (QA/IP), E4 (Corporate RN) and E7 (ADON) at the exit conference.	F 657		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for six (R25, R37, R47, R66, R68, and R75) out of thirty-three residents in the investigative sample the facility failed to ensure that the required interdisciplinary team (IDT) memebers participated in the care plan meetings and additionally, R66's care plan inaccurately included dentures. Findings include: State of Delaware Board of Nursing- "RN (registered nurse), LPN (licensed practical nurse) and NA (nurses aide)/UAP (unlicensed assistive personnel) Duties 2024...Admission Assessments - RN, Admission History Review -RN...Plan of Care: Initial- RN..." Updated 4/10/24 1. Review of R160's clinical record revealed:	F 658	The facility cannot retroactively correct this issue related to R160, R109, R144, R148, R157 and R461. Residents admitted to the Center have the potential to be affected. Root cause analysis determined that an LPN assigned to monitor resident care completed the required admission screening documents and initiated the baseline care plan. Facility procedures related to completing admission screener and baseline care plan will be revised to ensure that this practice does not continue to occur: an	9/4/24

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F 658	Continued From page 38 3/30/24 - R160 was admitted to the facility. 3/30/24 - E8 (LPN) completed the Prestige Admit/Readmit Screener. 4/3/24 - R160's baseline care plan was e-signed by E9 (LPN). An LPN, not an RN, as required by the Delaware State regulation for Board of Nursing Scope of practice, completed the admission assessment and baseline care plan for R160. 2. Review of R109's clinical record revealed: 6/14/24 - R109 was admitted to the facility. 6/14/24 - E17 (LPN) completed the following admission assessments: Resident Basics/Medical History, Elopement Risk Assessment, Pain Assessment, Fall Assessment, Skin Integrity/ Braden Scale, Mobility/Lift/Side Rail assessment, Oral/Nutrition assessment, Respiratory/Smoking Evaluation, Bowel & Bladder Assessment and IV/Other. 3. Review of R144's clinical record revealed: 3/21/24 - R144 was admitted to the facility. 3/25/24 - Baseline care plan was generated by E9 (LPN). 4. Review of R148's clinical record revealed: 3/21/24 - R148 was admitted to the facility. 3/21/24 - E23 (LPN) completed the following	F 658	RN will be assigned to review/sign the admission screener and baseline care plans. Licensed Nursing staff will be educated by Staff Development or designee regarding this change in procedure. Audit will be conducted of the medical records of residents admitted in the last 7 days to determine that an RN has reviewed and signed the admission screener and baseline care plan. Audits of medical records of admissions will be conducted daily with clinical meeting as part of the review of new admission process. This audit will be ongoing as it will be part of the daily clinical meeting. Results will be tabulated weekly for four weeks or until 100% compliance is achieved for two consecutive weeks, and then monthly for three months to verify that admission screeners and baseline care plans are reviewed/signed by RN. Results will be reported to the QAPI Committee monthly.	

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F 658	Continued From page 39 assessments: Resident Basics/Medical History, Elopement Risk Assessment, Pain Assessment, Fall Assessment, Skin Integrity/ Braden Scale, Mobility/Lift/Side Rail Assessment, Oral/Nutrition Assessment, Respiratory/Smoking Evaluation, Bowel & Bladder Assessment and IV/Other. 3/25/24 - The baseline care plan was generated by E9 (LPN). 6/17/24 - R148 was re-admitted to the facility. 6/17/24 - E18 (LPN) completed the follwoing assessments: Resident Basics/Medical History, Elopement Risk Assessment, Pain Assessment, Fall Assessment, Skin Integrity/ Braden Scale, Mobility/Lift/Side Rail Assessment, Oral/Nutrition Asessment, Respiratory/Smoking Evaluation, Bowel & Bladder Assessment and IV/Other. 5. Review of R157's clinical record revealed: 6/19/24 - R157 was admitted to the facility. 6/19/24 - E22 (LPN) completed the following assessments: Resident Basics/Medical History, Elopement Risk Assessment, Pain Assessment, Fall Assessment, Skin Integrity/ Braden Scale, Mobility/Lift/Side Rail Assessment, Oral/Nutrition Assessment, Respiratory/Smoking Evaluation, Bowel & Bladder Assessment and IV/Other. 6/20/24 - The baseline care plan was generated by E9 (LPN). 6. Review of R461's clinical record revealed: 6/19/24 - E24 (LPN) completed the following assessments: Resident Basics/Medical History,	F 658		

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F 658	Continued From page 40 Elopement Risk Assessment, Pain Assessment, Fall Assessment, Skin Integrity/ Braden Scale, Mobility/Lift/Side Rail Assessment, Oral/Nutrition assessment, Respiratory/Smoking Evaluation, Bowel & Bladder Assessment and IV/Other. 7/17/24 9:19 AM - During an interview, E8 (LPN) stated that she has done admit/readmit screener on the electronic medical record (EMR) for newly admitted residents. The admit/readmit screener was defined as "vitals, a skin check and a whole list of questions that we have to ask regarding things like fall and dentures and so on." When asked about the baseline care plan, E8 stated that the unit manager does the care plan. 7/18/24 1:05 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (QA/IP), E4 (corporate RN) and E 7 (ADON) at the exit conference.	F 658		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ...	F 676		9/11/24

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F 676	Continued From page 41 §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that for one (R128) out of seven residents reviewed for ADLs, the facility failed to provide mobility from bed to chair. Findings include: Cross refer F842. Review of R128's clinical record revealed: 8/11/23 - R128 was admitted to the facility with diagnoses including cerebral infarction and hemiplegia affecting the nondominant left side. 4/23/24 - A physician order documented that R128 was to be out of bed for a minimum of two hours every day and nursing to document and	F 676	Physician Order for R128 was revised to document refusals. Residents with orders to be out of bed to chair could have the potential to be affected. The root cause was lack of oversight of staff to assure that physician specific orders for OOB are followed and any refusals are documented. Nursing Staff was educated on the importance of ensuring that residents with orders to be out of bed are carried out and any refusals are documented. Staff Development/Designee will educate nursing staff and new hires on the importance of assuring that residents with orders to be out of bed are carried out and	

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F 676	Continued From page 42 notify family of refusals every day shift. 5/16/24 - A quarterly MDS revealed that R128 had an impairment on one side for the upper extremities and no impairments for the lower extremities. R128 required substantial or maximal assistance for rolling left and right, sitting to lying, lying to sitting on the side of the bed and was dependent for transfer from bed to chair or chair to bed. R128's BIMs score was 13 out of 15 which indicated intact cognition. 7/9/24 - An interview with R128 stated, "I stay in bed and they don't get me up." Observations of R128 laying in bed: 7/10/24 at 10:32 AM, 7/10/24 at 11:14 AM, 7/11/24 at 9:35 AM, 7/11/24 at 10:41 AM, 7/11/24 at 12:11 PM, 7/11/24 at 2:56 PM. 7/12/24 9:33 AM - During an interview R128 stated he did not get out of bed at any time on 7/11/24. 7/12/24 2:29 PM - During an interview, E25 (CNA) confirmed that R128 did not get out of bed on 7/11/24 and that R128 did not refuse. E25 stated, "we did not ask if he wanted to get up. He usually tells us that he wants to be up. We did not ask, so he did not refuse." 7/12/24 2:31 PM - During an interview, E26 (LPN) stated, "we have to document about him refusing in the [electronic] notes." There was no facility documentation of any refusals by R128 to get out of bed on 7/11/24. 7/18/24 1:05 PM - Findings were reviewed with	F 676	any refusals are documented Observation of residents who need assistance or have specific orders to be out of bed will be conducted by ADON or designee weekly for four weeks or until 100% compliance is achieved for two consecutive weeks. Observations will then be conducted monthly for three months to verify that the compliance is continued. Results reported to QAPI Committee monthly.	

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F 676	Continued From page 43 E1 (NHA), E2 (DON), E3 (QA/IP), E4 (Corporate RN) and E7 (ADON) at the exit conference.	F 676		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R146) out of ten resident reviewed for hospitalization, the facility failed to ensure that R146's warfarin dosing was managed in accordance with the professional standards of practice. Findings include: The acceptable time frame to achieve anticoagulation with warfarin typically ranges from 5 to 7 days. However, it's important to note that the full therapeutic effect may take up to a week due to the long half-life of prothrombin (factor II), which is essential for converting fibrinogen to fibrin12. Warfarin inhibits the production of vitamin K-related factors, and its antithrombotic effect gradually becomes evident as prothrombin levels decrease. During this period, concurrent use of more rapidly acting anticoagulants, such as low-molecular-weight heparin (LMWH) or unfractionated heparin, is recommended. National Library of Medicine, Turkish Journal of Hematology 2016	F 684	R109 no longer resides in the facility. Unable to correct for this resident. Residents with orders for coumadin have the potential to be affected. The root cause is determined to be lack of physician oversight and management of INRs of residents with coumadin therapy based on standardized warfarin dosing guidelines. Providers will be educated by the Medical Director regarding Coumadin management relative to INRs. The Medical Director/Designee will educate the providers and newly hired Providers regarding Coumadin Management relative to INRs. Audits of medical records of residents with warfarin therapy and INR will be conducted to assure that warfarin therapy is based on standardized warfarin dosing guidelines. Audits will be conducted by DON, with Medical Director review of findings. Audits will be completed weekly	9/11/24

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F 684	Continued From page 44 Warfarin Dosing Guideline- ...V. Warfarin dosing nonogram (in medicine, a pictorial representation of a complex mathematical formula) for Maintenance therapy (>1 week of warfarin therapy) of non-bleeding patient Goal INR 2-3 Dosing Adjustments INR <1.5 - Consider a one-time dose increase of 1.5-2 times daily maintenance dose -If adjustment to maintenance dose is needed, increase dose by 10-20% -Repeat INR in 1 week INR 1.5-1.7 -Consider a one-time dose increase of 1.5 times daily maintenance dose -If adjustment to maintenance dose needed, increase by 5-15% - Repeat INR in 2 weeks INR 1.8-1.9 -No dosage adjustment may be necessary if the last two INRs were in Range -Repeat INR within 8 weeks -Consider a one-time dose increase of 1.5 times daily maintenance dose -If adjustment to maintenance dose needed, increase dose by 5-10% -Repeat INR in 2 weeks (University of New Mexico Health System June 2020) Review of R109's clinical record revealed: 6/14/24 - R109 was admitted to the facility with diagnoses, including but not limited to, atrial fibrillation (Afib), deep vein thrombosis (DVT) and factor V Leiden heterozygous mutation, an inherited disorder that causes abnormal blood	F 684	for four weeks or until 100% compliance is achieved consistently for two consecutive weeks and then monthly for three months. If results are consistently 100%, the QAPI Committee may determine that the deficient practice has been resolved. Results will be reported to the QAPI Committee monthly.	

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F 684	Continued From page 45 clots in legs or lungs. Due to the risk of blood clots, R109 was medically managed with warfarin for anti-coagulation therapy with the goal INR range of 2.0 to 3.0. (University of New Mexico Health System June 2020) 6/14/24 Friday - E39 (MD) documented in R109's EMR, "Warfarin tablet 2 mg (milligram) - give 1 tablet by mouth in the evening every Sat, Sun" and "Warfarin tablet 2 mg- vie 1.5 tablet (3 mg) by mouth in the evening every Mon, Tues, Wed, Thu, Fri." Total weekly warfarin dosage was 19 mg. 6/15/24 Saturday 11:12 AM - R109's INR was reported as 1.5, which was not at R109's therapeutic goal of 2.0 to 3.0. The facility lacked evidence of any intervention for this below goal INR level. 6/18/24 Tuesday 12:06 PM - R109's INR was reported as 1.2, which was not R109's therapeutic goal of 2.0 to 3.0. 6/19/24 - E38 (NP) documented in R109's EMR, "Warfarin tablet 2 mg- give 1.5 tablets (3 mg) by mouth in the evening every Mon, Tue, Wed, Thu, Fri, Sat, Sun." Total weekly warfarin dosage was 21 mg. This reflected an increase of 2 mg or 10 % of the total weekly warfarin dosage. 6/21/24 Friday 11:45 AM - R109's INR was reported as 1.3, which was below R109's therapeutic goal of 2.0 to 3.0.	F 684		

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	085037	A. BUILDING _____ B. WING _____	C 07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLANTIC SHORES REHABILITATION & HEALTH CENTER	231 SOUTH WASHINGTON STREET MILLSBORO, DE 19966

(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 684	Continued From page 46 This was day 7 of anti-coagulation therapy in the facility and R109 did not reach the desired goal of INR 2.0 to 3.0. 6/21/24 - E38 (NP) documented in R109's EMR, "Warfarin tablet 2 mg- give 2 tablets (4 mg) by mouth in the evening every Mon, Fri, Sun" and "give 1.5 tablets (3 mg) by mouth at bedtime every Tue, Wed, Thu, Sat." Total weekly warfarin dosage was 24 mg. This reflected an increase of 3 mg or 14.3 % of the total weekly warfarin dosage. 6/25/24 Tuesday 12:23 PM - R109's INR was reported as 1.7, which was still below R109's desired goal of 2.0 to 3.0. 6/25/24 - E38 (NP) documented in R109's EMR, "Warfarin tablet 2 mg- give 2 tablets (4 mg) by mouth in the evening every Mon, Tue, Wed, Fri, Sun" and "give 1.5 tablets (3 mg) by mouth at bedtime every Thu, Sat." Total weekly warfarin dosage was 26 mg. This reflected an increase of 2 mg or 7.7 % of the total weekly warfarin dosage. 6/26/24 - R109 was hospitalized for shortness of breath. During this hospitalization, R109 was treated with lovenox, an heparin injection, to help reach the desired anti-coagulation goal as R109's INR was not at goal upon admission to the hospital. 6/30/24 - R109 was re-admitted to the facility. 6/30/24 - E38 (NP) documented in R109's EMR,	F 684		

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F 684	Continued From page 47 "Warfarin tablet 2 mg- give 2 tablets (4 mg) by mouth in the evening every Mon, Tue, Wed, Fri, Sun" and "give 1.5 tablets (3 mg) by mouth at bedtime every Thu, Sat." Total weekly warfarin dosage was 26 mg. 7/2/24 Tuesday 12:10 PM - R109's INR was reported as 1.2, which was not at R109's desired goal of 2.0 to 3.0. 7/3/24 Wednesday - E38 (NP) ordered in R109's EMR, "Warfarin tablet 2 mg- give 2 tablets (4 mg) by mouth in the evening." Total weekly warfarin dosage was 28 mg. E45 (NP) also ordered, "Warfarin tablet 1 mg- give 1 tablet (1 mg) by mouth at bedtime every Wed, Thu for 2 days for a total dose of 5 mg." With the additional 2mg of warfarin, the total weekly dosage was 30 mg. This one-time dose increase did not meet the professional standard guidelines of "a one-time dose increase of 1.5-2 times daily maintenance dose". This reflected an increase of 4 mg or 15.4 % of the total weekly warfarin dosage. 7/9/24 12:08 PM - R109's INR was reported as 1.4, which was below R109's therapeutic goal of 2.0 to 3.0. 7/9/24 - E38 (NP) ordered in R109's EMR, "Warfarin tablet 1 mg- give 1 tablet (1 mg) by mouth at bedtime every Tue, Wed, Thu. Give in addition to 2 mg tabs (total dose= 5 mg)." Total weekly warfarin dosage was 31 mg. This reflected an increase of 3 mg or 10.7 % of the total weekly warfarin dosage.	F 684		

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F 684	Continued From page 48 This was day 9 of anti-coagulation therapy in the facility after R109's re-admission to the hospital and R109's INR remained below therapeutic goal of 2.0 to 3.0. 7/12/24 12:33 PM - R109's INR was reported as 1.2, which did not meet R109's therapeutic goal of 2.0 to 3.0. 7/12/24 - E38 (NP) ordered in R109's EMR, "Warfarin tablet 1 mg- give 1 tablet (1 mg) by mouth at bedtime. Give in addition to 2 mg tabs (total dose = 5 mg)" and "Warfarin tablet 2 mg- give 2 tablets by mouth at bedtime. Give in addition to 1 mg tab. Total dose =5mg)." Total weekly warfarin dosage was 35 mg. This reflected an increase of 4 mg or 12.9 % of the total weekly warfarin dosage. 7/15/24 12:34 PM - During an interview, E38 (NP) stated that he looked up the hospital records from the 6/26/24 admission and reviewed the Hematology consult note. "I decided not to bridge with lovenox. There was conflicting documentation in the discharge summary regarding whether to bridge or not. I am following the INR and am increasing the dosage with each INR result." 7/16/24 - R109's INR was reported as 1.5, which was below R109's desired goal of 2.0 to 3.0. This was day 16 of anti-coagulation therapy in the facility after R109's re-admission to the hospital and R109's INR did not reach the therapeutic goal of 2.0 to 3.0.	F 684		

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F 684	Continued From page 49 7/16/24 - E38 (NP) ordered in R109's EMR, "Warfarin tablet 2 mg- give 3 tablets (6 mg) by mouth at bedtime." Total weekly warfarin dosage was 42 mg. E45 (NP) also ordered, "Warfarin tablet 2 mg- give 4 tablet (8 mg) by mouth at bedtime for 1 day." With the additional of the one-time 8mg dosage, the weekly warfarin dosage was 50 mg. This reflected an increase of 15 mg or 42.8 % of the total weekly warfarin dosage. 7/18/24 12:14 PM - During a telephone interview, E39 (MD) confirmed that R109's INR goal for anti-coagulation therapy was 2-3. With regard to the timeframe that it was taken to achieve this goal, E39 stated, "It has taken too long." Of note, at the time of the survey team exit, the facility was still unable to provide evidence that R109 was therapeutically anti-coagulated with warfarin. 7/18/24 1:05 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (QA/IP), E4 (Corporate RN) and E7 (ADON) at the exit conference.	F 684		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary	F 690		9/11/24

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F 690	Continued From page 50 incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined that for two (R123 and R143) out of three residents reviewed for bowel and bladder, the facility failed to respond to or provide services to restore bladder continence. Findings include: 1. Review of R123's clinical record revealed: 2/15/24 - R123 was admitted to the facility. 2/20/24 - A bowel and bladder initial assessment	F 690	R123 and R143 were placed on voiding diary and toileting program. R123 was scheduled for an appointment with a urologist. Current residents who are incontinent have the potential to be affected. An audit was completed for all current residents to verify that voiding diaries and toileting plans were initiated appropriately. Schedule was developed in coordination with MDS completion to ensure that	

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F 690	Continued From page 51 revealed that R123 was continent of bowel and bladder. 2/21/24 - An admission MDS assessments revealed that R123 was always continent of bowel and bladder and not indicated for a toileting program. April 2024 - A review of the April CNA task flow sheet revealed that R123 was incontinent of bladder sixty-five times out of ninety opportunities. 5/21/24 - A quarterly MDS assessment revealed that R123 was frequently incontinent of bladder and always incontinent of bowel and not indicated for a toileting program. May 2024 - A review of the May CNA task flow sheet revealed that R123 was incontinent of bladder seventy-two times out of ninety opportunities. June 2024 - A review of the June CNA task flow sheet revealed that R123 was incontinent of bladder eighty-fives times out of ninety opportunities. July 2024 - A review of the July CNA task flow sheet revealed that R123 was incontinent of bladder twenty-nine times out of thirty-three opportunities. 7/15/24 12:53 PM - An interview with E40 (CNA) confirmed that R123 is usually incontinent and unable to recall if R123 was on a toileting program. E40 stated that R123 was on a different unit previously and was using a urinal. E40 stated she does not offer a urinal or commode to R123.	F 690	voiding diaries are completed and implementation/revision of toileting plans completed as appropriate. The root cause was determined to be due to lack of oversight to ensure residents assessed as incontinent had voiding diary completed along with toileting programs were initiated as applicable. Licensed Nurses will be educated re: voiding diaries and development of toileting programs. ADON developed a monthly schedule to capture the need to initiate new voiding diaries. This is completed for all admissions, on quarterly and annual assessments and for all residents identified with a significant change. Audits will be completed to ensure that voiding diary was initiated and toileting programs initiated as appropriate. Audits will be done weekly for four weeks and then monthly until 100% compliance is maintained for three months. Results will be reported to the QAPI Committee monthly.	

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F 690	Continued From page 52 7/15/24 1:45 PM - An interview with E41 (COTA) confirmed that therapy assessed R123 for use of urinal and bedside commode. E41 confirmed that R123 is able to utilize both adaptive equipment safely. 7/16/24 12:19 PM - An interview with E14 (RN Staff Educator) revealed that the voiding diary gives them an idea of target times to assist the resident with incontinence. Nursing is able to initiate adaptive equipment such as a urinal but therapy has to initiate a commode. E14 confirmed that R123 is not currently using a urinal or commode. The facility lacked evidence of responding to decreased continence and failed to provide evidence of services to restore continence for R123. 7/16/24 1:20 PM - An interview with E3 (QA), E7 (ADON), and E2 (DON) revealed that R123 was offered a urinal trial starting on 7/15/24. 2. Review of R143's clinical record revealed: 4/4/24 - R143 was admitted to the facility. 4/6/24 - An admission MDS revealed that R143 is occasionally incontinent of bowel and bladder and is not indicated for a toileting program. April 2024 - A review of the April CNA task flow sheet revealed that R143 was incontinent of bladder fifty-nine out of one hundred and one opportunities. May 2024 - A review of the May CNA task flow	F 690		

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F 690	Continued From page 53 sheet revealed that R143 was incontinent of bladder eighty-three out of one hundred and twenty-six opportunities. June 2024 - A review of the June CNA task flow sheet revealed that R143 was incontinent of bladder fifty-five out of ninety opportunities. July 2024 - A review of the July CNA task flow sheet revealed that R143 was incontinent of bladder twenty-eight out of thirty-eight opportunities. 7/5/24 - A voiding diary was completed for R143 from 7/3/24 to 7/5/24. The facility lacked evidence of implementing a plan to restore continence for R143. 7/17/24 10:25 AM - An interview with E20 (CNA) revealed that "[R143] is independent and will notify staff if she is incontinent. [R143] is able to clean herself up and I (E20) dont normally have to assist her." The facility lacked evidence of responding to decreased continence and failed to provide evidence of services to restore continence for R143. 7/18/24 1:05 PM - Findings were reviewed with E1 (NHA) , E2 (DON), E3 (QA/IP), E4 (Corporate RN) and E7 (ADON) at the exit conference.	F 690		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who	F 695		9/4/24

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F 695	Continued From page 54 needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, it was determined that for two (R47 and R121) out of two residents reviewed for respiratory care, the facility failed to provide respiratory care consistent with professional standards of practice. Findings include: 1. Review of R47's clinical record revealed: 5/27/16 - R47 was admitted to the facility with diagnoses including traumatic brain injury and tracheostomy status. 7/7/22 - A physician's order was written for R47 "Emergency Trach Supply list - Items are to be kept in a bag together at bedside/head of bed at all times 1. The same size trach 2. next size smaller trach 3. Ambu bag and mask 3. Sterile lubricant (2 packets) 4. Suction Machine with tubing 5. Suction Catheter 6. Oxygen tank/full 7. sterile gloves 8. Trach Ties *check for expiration dates and replace prn *." 5/22/24 - An annual MDS revealed that R47 required tracheostomy care. 7/15/24 9:15 AM - A review of the R47's physician's orders lacked evidence of current tracheostomy size and brand of use. 7/15/24 10:29 AM - An interview with E27 (LPN	F 695	Physician order for tracheostomy care for R47 was revised. Replacement tracheostomies are available at bedside of R47 according to physician order. R121□s O2 tubing was labeled and dated. Residents with tracheostomies and residents receiving O2 have the potential to be affected. Root cause was determined to be lack of thorough understanding of emergency tracheostomy care and procedures and weekly labeling and dating of oxygen tubing. Nursing Admin, Respiratory Therapist and Medical staff reviewed tracheostomy policy and procedure and competency evaluation of licensed nursing staff. Licensed Nursing staff was trained re: the policy and procedure and evaluated for competency. Nursing staff will be educated by Nurse Educator on labeling and dating of O2 tubing based on facility policy. Audits of residents with tracheostomy will	

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F 695	Continued From page 55 UM) revealed that all tracheostomy orders would be located in the EMR under orders. E27 confirmed R47's size and type of trach was not indiciated in EMR. E27 stated R46 is a size 6 based on the emergency equipment. 7/15/24 10:40 AM - A physician's order for R47 revealed that tracheostomy size #4 shiley was the current tracheostomy size and brand. 7/15/24 2:50 PM - An interview with E32 (RN) stated she was unsure of R47's trach size prior to today. 7/16/24 9:58 AM - An observation of a size #6 and size #4 replacement tracheostomy to be hanging at bed side with emergency equipment. 7/17/24 9:30 AM - An interview with E28 (NP) confirmed R47 should be a shiley #4 trach and that the facility does not have the proper equipment at this time to accommodate a smaller size as the emergency order states. 2. Review of R121's clinical record revealed: 10/27/23 - R121 was admitted to the facility with a diagnosis of acute respiratory failure with hypoxia (deficiency in amount of oxygen reaching body tissues). 11/10/23 - A physicians' order documented continuous oxygen at 2 liters/minute via nasal cannula (tube placed into nostrils to deliver oxygen). Change, date and initial tubing weekly and change humidifier bottle weekly and PRN, every night shift on Saturday. 7/9/24 11:10 AM - During an observation, the	F 695	be done to assure that physician orders are consistent with brand and size of trach in place. Audits will be done of residents with oxygen orders to ensure that tubing is labeled and dated weekly. Audits will be done for four weeks and monthly for three months to verify that that O2 tubing is labeled and dated.	

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F 695	Continued From page 56 oxygen tubing was not labeled with date and initials, this was confirmed with E30 (LPN).	F 695		
F 710 SS=D	Resident's Care Supervised by a Physician CFR(s): 483.30(a)(1)(2) §483.30 Physician Services A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. A physician, physician assistant, nurse practitioner, or clinical nurse specialist must provide orders for the resident's immediate care and needs. §483.30(a) Physician Supervision. The facility must ensure that- §483.30(a)(1) The medical care of each resident is supervised by a physician; §483.30(a)(2) Another physician supervises the medical care of residents when their attending physician is unavailable. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that for one (R47) out of two residents reviewed for respiratory care, the facility failed to ensure that the Physician's orders included trach size, type, and accurate emergency orders. Findings include: Review of R47's clincal record revealed: 5/27/16 - R43 was admitted to the facility. 7/7/22 - A physician's order was written for R47 "Emergency Trach Supply list - Items are to be	F 710	Physician order for tracheostomy care for R47 was revised. Replacement tracheostomies are available at bedside of R47 according to physician order. Residents with tracheostomies have the potential to be affected. Root cause was determined to be lack of oversight of resident with tracheostomy in ensuring physician orders are consistent with resident care. and ensuring	9/4/24

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F 710	Continued From page 57 kept in a bag together at bedside/head of bed at all times 1. The same size trach 2. next size smaller trach 3. Ambu bag and mask 3. Sterile lubricant (2 packets) 4. Suction Machine with tubing 5. Suction Catheter 6. Oxygen tank/full 7. sterile gloves 8. Trach Ties *check for expiration dates and replace prn *." 7/15/24 9:15 AM - A review of the R47's physician's orders lacked evidence of current tracheostomy size and brand of use. 7/15/24 10:29 AM - An interview with E27 (LPN UM) revealed that all tracheostomy orders would be located in EMR under orders. E27 confirmed R47's size and type of trach was not indiciated in EMR. 7/15/24 10:40 AM - A physician's order for R47 revealed that tracheostomy size #4 shiley is current tracheostomy size and brand. 7/17/24 11:50 AM - An interview with E28 (NP) confirmed that the emergency order instructions were not accurate for R47's plan of care. The facility failed to have a current order for R47's tracheostomy that included type and size and failed to have accurate emergency order's, 7/18/24 1:05 PM - Findings were reviewed with E1 (NHA) , E2 (DON), E3 (QA/IP), E4 (Corporate RN) and E7 (ADON) at the exit conference.	F 710	emergency trach size and type are in place. Respiratory Therapist/Designee will educate providers and Licensed nursing staff on obtaining physician orders consistent with resident care and ensuring appropriate emergency Trach size, brand orders are in place. Random audits of physician orders for residents with tracheostomy on size and brand will be done. Licensed Nurses competencies will be monitored to verify demonstrated competency in care consistent with orders. Audits will be done weekly x 4 weeks, then monthly x 3 months. Results will be reported to the QAPI Committee monthly.	
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with	F 726		9/4/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085037	A. BUILDING _____ B. WING _____	C 07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLANTIC SHORES REHABILITATION & HEALTH CENTER	231 SOUTH WASHINGTON STREET MILLSBORO, DE 19966

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F 726	Continued From page 58 the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and review of the clinical record, it was determined that for one (R47) out of two residents reviewed for respiratory care, the facility failed to have nursing staff with the appropriate competencies and skill sets to provide nursing and related services to a resident with a tracheostomy. Findings include: Review of R47's clinical record revealed:	F 726	No negative impact noted for R47. All licensed nursing staff have the potential to be affected. The root cause was determined to be the staff□s lack of thorough understanding regarding tracheostomy care during emergency tracheostomy procedures and	

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F 726	Continued From page 59 5/27/16 - R47 was admitted to the facility with the following but not limited to diagnoses traumatic brain injury and tracheostomy status. 5/22/24 - An annual MDS revealed that R47 required tracheostomy care. 7/15/24 02:58 PM - An interview with E32 (RN) stated she was unsure of R47's trach size prior to today. 7/17/24 10:30 AM - An interview with E36 (Agency LPN) revealed "in an emergency you would insert the smaller size trach if it comes out." 7/17/24 10:45 AM - An interview with E37 (Agency LPN) revealed that E37 was unable to articulate what to do in an emergency with a tracheostomy resident. E37 stated "I would call the supervisor for help." 7/17/24 12:30 PM - A review of tracheostomy care competency checklists provided by E14 (Staff Educator RN) revealed that the facility lacked evidence of verifying compentcies with all agency nurses and lacked evidence of all staff being verified for emergency tracheostomy procedures. 7/18/24 1:05 PM - Findings were reviewed with E1 (NHA) , E2 (DON), E3 (QA/IP), E4 (Corporate RN) and E7 (ADON) at the exit conference.	F 726	related to size of the tracheostomy. Education was conducted with Licensed Nursing staff re: emergency procedures care for tracheostomy. Competencies in emergency tracheostomy care were completed with Licensed nurses. D. Interviews of Licensed nursing staff will be completed to assess competency of tracheostomy care and emergency procedures. Interviews will be conducted weekly x 4 weeks then monthly x 3 months. Results will be reported to QAPI committee.	
F 745 SS=D	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide	F 745		9/4/24

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F 745	Continued From page 60 medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R146) out of three residents reviewed for abuse, it was determined that the facility failed to provide medically related social services to R146, who was cognitively impaired and did not have a legal decision maker. Findings include: Cross refer F582, F602 and F609. Review of R146's clinical record revealed: 3/30/24 - R146 was admitted to the facility with diagnoses, including but not limited to altered mental status. 4/1/24 3:09 PM - R146 signed the facility's Admission Agreement, which included an authorization form to release financial data. The clauses that identified R146's "legal representative" and "responsible party" were left blank in this signed document. The facility's Admission Agreement included information regarding resident's rights, payment obligations, grievance process, advanced directive and other services provided by the facility. 4/2/24 2:59 PM - E5 (Social Work Director) documented in R146's EMR. " ...Her sister [F2] was invited to the meeting (care plan meeting) ...SW (social work) was unable to get in contact with her sister ...The plan is to have [R146] move	F 745	Attorney ad litem was appointed for R146 on July 9, 2024. Report was filed with the court on August 12, 2024 which recommended the appointment of a public guardian. There is no guardianship hearing scheduled at this time. Follow up is being conducted by NHA and BOM. Residents admitted from the hospital for long term care with BIMS <8 and no legal representative are potentially affected. Sweep of current residents admitted in the last three months will be conducted by NHA to identify those with BIMS <8 and no legal representative. In the absence of next of kin willing to assist the resident with financial and medical decision-making, the BOM will initiate competency evaluations and refer for potential guardianship. When residents with a BIMS <8 and no legal representative are admitted for or transition to long term care, competency evaluation and guardianship referral will be initiated. Audits will be conducted by NHA or designee weekly X 4 of admissions identified with BIMS <8 and no legal representation to ensure that residents have appropriate representation, then	

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F 745	Continued From page 61 in with one of her sisters ...[R146] scored 3/15 on her BIMS assessment which indicates that she has severe cognitive deficit ...". 4/5/24 - R146's admission Minimum Data Set (MDS) assessment documented a BIMS score of three, which reflected severe cognitive impairment. 4/9/24 9AM - E6 (SW) documented in R146's EMR "Update delivered to family and CM (case management) in phone call." The facility failed to identify that R146 with a BIMS of 3, did not have the cognitive ability to be her own responsible party and was unable to provide evidence of any intervention on behalf of R146 to address the need for a "responsible party" with R146's two known sisters. 4/12/24 - R146 was given a Notice of Medicare Non-Coverage (NOMNC) that advised that R146's effective date of last day of Medicare coverage was 4/17/24. The document was signed by E44 (Social Worker) and E43 (Business Office manager) with the statement "unable to sign BIM of 3" written in box beneath the statement "Signing below means that you've received and understand this notice ...". 4/15/24 10:58 AM - E5 (SW director) documented in R146's EMR, " ...[R146] received a NOMNC letter with a last cover date of 4/17/24. [R146]'s original discharge plan was to return home alone or to live with one of her sisters. [R146] does not feel like she can live on her own. It was reported to the social services department that she can no longer live with her sister ...SW (social work) will work with [R146] and her family to assist with	F 745	monthly X 3 or until 100% compliance is maintained for three consecutive months. Results will be reported to QAPI Committee monthly.	

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F 745	Continued From page 62 getting her transferred to another facility." 4/17/24 - R146 was cut from Medicare insurance coverage and deemed private pay at the rate of $495 per day, as stated in the Admission Agreement, for her stay at the facility. 4/18/24 4:04 PM - E5 (SW Director) documented in R146's EMR, " ...[R146] was scheduled for discharge today to her sister, [F3]. SW spoke with both of [R146]'s sisters. [F3], she states that her daughter called this morning and left a message on the admission director's voicemail stating that the resident cannot come and live with her. [F3] also wants to be removed from the electronic medical record as a point of contact for [R146]. SW spoke with the resident's other sister, [F2]. She states that she did not know that the resident could not go home with her other sister. [F3] said that she is home with COVID. F3 will revisit the resident coming home to live with her once she is systematic (sic). SW updated the IDT (interdisciplinary team) that [R146] will not be discharged today." The facility continued to fail to identify a "responsible party" for R146 and failed to initiate a referral to the medical staff for a capacity determination. 5/19/24 3:43 PM - E45 (RN) documented in R146's EMR that a family member called and requested that R146 should not sign anything without her family present. According to the Release of Responsibility for Leave of Absence log, R146 was signed out and left the facility on a leave of absence with unrelated persons on 5/20/24, 5/25/24, 6/3/24,	F 745		

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F 745	Continued From page 63 6/21/24, 6/28/24 and 7/12/24. The facility failed to verify that the persons had authorization to take R146 out of the building. 5/14/24 1:52 PM - E5 documented in R146's EMR,"[R146]'s sister called and stated that she wanted referred (sic) to [assisted living] facility program. SW spoke with [R146] and she agreed with a referral to be sent to [assisted living facility]. SW completed the referral and now awaiting a response from [assisted living facility] to see if they will accept [R146]." 5/24/24 9:48 AM- E5 (SW) documented in R146's EMR, "[R146] visited [assisted living facility] on Monday with her sister. [R146] had been referred to [assisted living facility] for possible placement. [R146] had been accepted by [assisted living facility]. [R146] provided a deposit for [assisted living facility]. There are other documents that need to be filled out by her sister and the n here. There is no set discharge date for [R146] at this time. IDT team has been made aware." 5/28/24 1:15 PM - E44 (SW) documented in R146's EMR, "SW added new contact in PCC (Point Click Care) w/permission of [R146]. Her male friend [F4] xxx-xxx-xxxx." 5/29/24 - E46 (Psychologist) documented in R146's EMR, "Her judgment and insight are impaired. At this time, pt is not capable of making her own healthcare decisions." 5/31/24 - The facility made a referral for capacity determination. This capacity referral was made fifty-six (56) days	F 745		

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F 745	Continued From page 64 after the initial BIMS assessment that documented R146 having a severe cognitive impairment. 6/3/24 - E39 (MD) documented in a Physician Affidavit for Guardianship that R146 did not have capacity to function independently including: activities of daily living, pay her own bills, live alone, take medicine appropriately, give consent for medical procedures and resist scams. 6/3/24 10:06 AM - F4 (male friend) signs R146 out of the facility in the Leave of Absence log. R146 was signed back into the facility at 11:35 AM. 6/4/24- The facility petitioned the Court of Chancery to initiate R146's guardianship process. This petition was initiated one (1) day after R146 was deemed not to have capacity and sixty (60) days after R146 was documented to have a severe cognitive impairment and lacked family/community support. 7/9/24 1:54 PM - During a telephone interview, F2 (R146's sister) stated that she was not informed about R146's last day of Medicare coverage nor was she offered the opportunity to appeal. F2 also confirmed that she was not asked about allowing R146 to go out the facility with unrelated persons. 7/9/24 - The Court of Chancery filed paperwork that appointed C3 (Esquire) as attorney ad litem of R146, "a person with an alleged disability" and stated the hearing for guardianship would be on August 15, 2024.	F 745		

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F 745	Continued From page 65	F 745		

7/10/24 10:24 AM - E5 (SW) documented in R146's EMR, "[R146]'s care plan meeting was rescheduled until July 23rd at her request. IDT team was made aware of her meeting being rescheduled. "

7/10/24 3:20 PM - A review of R146's face sheet revealed that R146 listed as "responsible party" and F2 (R146's sister) listed as emergency contact #1 and F3 (R146's other sister) listed as emergency contact #2.

Ninety-six (96) days after R146 was documented as having severe cognitive impairment and thirty-seven (37) days after R146 was deemed not to have capacity, R146's face sheet continued to document that R146 was her own responsible party.

7/12/24 9:31 AM - During an interview, E44 (SWS) stated, "When I was explaining about the insurance, she did not understand. She did not understand what she was signing so she did not sign. She would nod her head in agreement, but she did not understand."

7/12/24 10:54 AM - During an interview, F5 (CSA, female friend), "I don't have a contract with [R146]. I just really like her and am keeping touch because I like her. I have taken [R146] to Dairy Queen, my grandson's birthday party, out for lunch. She has met my daughter. I have never taken her to the bank. She does not have any money. I heard [F4] and [F3] were trying to get POA (power of attorney)."

7/12/24 11:03 AM - During an interview, E1 (NHA) stated, "We were trying to get a Medicaid application together. When we got the bounced

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F 745	Continued From page 66 check, that was when we became aware that there was a problem. That was in May sometime. No, I did not report it to APS." 7/12/24 1:07 PM - When shown a copy of the facility "Release of Responsibility for Leave of Absence" log, F5 (CSA, female friend) stated, "Yes, that is my chicken scratch" (pointing to the dates of 5/20, 5/25, 6/21, 6/28, & 7/12 on the release log). F5 then stated that the signature on 6/3 was F4 (male friend). "I remember seeing them here on 6/3; it's my birthday." 7/12/24 3:13 PM - During an interview, E1 (NHA) stated, "We don't have a policy or procedure for residents that have been deemed not to have capacity and don't have a legal guardian or POA (power of attorney)." 7/15/24 10:15 AM - During a telephone interview, F2 (R146's sister) reported that R146's roommate F7 alleged that F4 came to the facility and had R146 call the bank to have another debit card mailed to R146's apartment and F4 was the person who picked up R146's mail. 7/15/24 11 AM - The surveyor informed the facility of the allegation against F4 who was listed on R146's face sheet as "friend". 7/15/24 12:29 PM - During an interview, E38 (NP) stated, "There are no special orders that we place when a patient is deemed not to have capacity. We were not aware that [R146] had been financially exploited." 7/15/24 5:30 PM- After inquiry by the surveyor, E2 (DON) filed a complaint with the [local] police regarding R146's returned check #4483 from	F 745		

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F 745	Continued From page 67 5/23/24 for insufficient funds. 7/16/24 10:10 AM - During an interview, E5 (SW) stated, "To my knowledge, there is no policy or precedent regarding when a resident is deemed not to have capacity. I am not aware of any restrictions regarding leaving the facility. I guess you would call her sister. I am not aware of a guardian ad litem." 7/16/24 11:42 AM - During an interview, E1 (NHA) stated, "The facility petitioned for guardianship on 6/4/24. The referral for capacity was made on 5/31/24. [R14]'s need for a capacity determination was discussed and decided at morning meeting so there are no notes from an IDT meeting about it. If [R146} wants to leave the facility with friends, we allow her to go." 7/18/24 - F4 (male friend) remained listed on R146's face sheet as a "friend". 7/18/24 1:05 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (QA/IP), E4 (Corporate RN) and E7 (ADON) at the exit conference.	F 745		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility	F 812		9/4/24

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F 812	Continued From page 68 gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility failed to ensure food was stored, prepared, and served in a manner that prevents food borne illness to the residents. Findings include: 7/9/24 11:05 AM - Observation of nourishment refrigerator located at the nurse's station number two (2) revealed a carton of Nutritional Shake that was undated. The instructions on the carton indicate that once opened, any remaining product should be discarded after four (4) days. 7/9/24 11:06 AM - The food storage shelves in the walk-in refrigerator were covered in numerous areas of rust, the floor of the walk-in was wet, and there was some small areas of ice build up in the walk-in freezer. 7/9/24 11:27 AM - During a tour of the kitchen, the surveyor observed E48 (Dining Services Director) and E49 (Assistant Dining Services Director) test the sanitizer level of the solution in two red sanitizing buckets. When E49 tested the sanitizing solution in the bucket from the prep area, the test strip from that bucket indicated that the level of chemical concentration was not at a sufficient level to provide proper sanitization.	F 812	No residents were identified. All residents are potentially affected. 1. The sanitizing solution in red sanitizer buckets was immediately discarded after the food service manager and surveyor identified that the solution was not at the appropriate concentration level. The food service manager re-filled the red sanitizer buckets, tested to ensure the sanitizing solution was within the appropriate range and re-distributed the buckets throughout the kitchen. 2. The ice build up that was identified on the freezer floor was addressed immediately by food service managers. The ice was removed and freezer floor was swept and mopped to ensure it was clean and free of debris. 3. All items, in the nourishment refrigerators throughout the facility, that were not properly labeled and dated were immediately discarded. The root cause analysis determined that staff failed to follow policy and procedure for food safety and sanitation by: the ineffectiveness of the sanitizing solution, and items found in pantry refrigerators past the expiration date, and the ice build	

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F 812	Continued From page 69 7/18/24 1:05 PM - Findings were reviewed with E1 (NHA) , E2 (DON), E3 (QA/IP), E4 (Corporate RN) and E7 (ADON) at the exit conference.	F 812	up found on the freezer floor. All dietary staff received additional education by food service director and regional consultant, on Food safety and sanitation related to the freezer floor, sanitizing solution, and labeling and dating of all items in the pantry refrigerators. In addition, the dietary employee who delivers snacks to the units will check the pantry refrigerators daily to ensure all items are properly labeled, dated, and discarded if necessary. The food service director will audit the cleanliness of the freezer floor, pantry refrigerators for labeling and dating of all items leaving the kitchen, and the sanitizing solution effectiveness. The audits will be completed daily for three days, then weekly for three weeks, and monthly for three months. Results of all audits will be presented to the Quality Assurance and Performance Improvement Committee.	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records.	F 842		9/4/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085037	A. BUILDING _____ B. WING _____	C 07/18/2024

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F 842	Continued From page 70 §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches	F 842		

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F 842	Continued From page 71 legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R128) out of thirty-three (33) residents in the investigative sample, the facility failed to ensure the clinical record contained accurate documentation. Findings include: Cross refer F676. Review of R128's clinical record revealed: 8/11/23 - R128 was admitted to the facility. 4/23/24 - R128's physicians orders documented R128 to be out of bed for a minimum of two hours every day and nursing to document and notify family of refusals every day shift. 5/16/24 - A quarterly MDS revealed that R128 was dependent for transfer from bed to chair or chair to bed. R128's BIMs score was 13 out of 15 which indicated intact cognition.	F 842	The facility cannot retroactively correct the issue related to R128. Residents with orders to be out of bed to chair have the potential to be affected. The root cause was determined to be a lack of oversight of staff with and documentation of refusals when there is an order for out of bed. Nurse Educator/Designee will educate nursing staff to ensure accurate documentation is reflected in the medical records. A random observation of residents with orders to be out of bed to chair will be conducted to ensure care is provided based on orders and any refusals documented. Audits will be done weekly x3, then monthly audit x3, Results reported to QA meeting monthly.	

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F 842	Continued From page 72 7/10/24 at 10:32 AM - 7/11/24 at 2:56 PM - Multiple observations of R128 laying in bed. 7/12/24 9:33 AM - During an interview R128 stated he did not get out of bed at any time on 7/11/24. A review of the treatment administration record (TAR) revealed a checkmark with E8 (LPN)'s initials for the treatment order that states, "Resident to be out of bed for a minimum of 2 hours every day - Nursing to document and notify Sister ... of refusals every day shift." 7/12/24 2:29 PM - During an interview, E25 (CNA) confirmed that R128 was not out of bed on 7/11/24 and they did not offer to get R128 out of bed. 7/12/24 2:31 PM - During an interview E26 (LPN) stated, "we have to document about him refusing in the [electronic] notes." 7/17/24 9:19 AM - During an interview E8 confirmed that the checkmark on the treatment administration record for 7/11/24 means that the task was completed and R128 got out of bed. There was a lack of facility documentation of any refusals by R128 to get out of bed on 7/11/24. The facility documented that R128 was out of bed when he was never out of bed on 7/11/24. 7/18/24 1:05 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (QA/IP), E4 (Corporate RN) and E7 (ADON) at the exit conference.	F 842		
F 867 SS=C	QAPI/QAA Improvement Activities	F 867		9/4/24

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F 867	Continued From page 73 CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to	F 867		

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F 867	Continued From page 74 prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms	F 867		

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F 867	Continued From page 75 that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on review of facility documentation, review of cited deficiencies from the facility's annual survey of 7/14/23 and staff interview, it was determined that the facility's Quality Assurance	F 867	No residents affected. Root cause is that outdated policy related to MRR was provided to the Survey team	

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F 867	Continued From page 76 and Performance Improvement (QAPI) program failed to correct previously cited deficiencies. Findings include: 7/11/24 - A review of the facilities undated policy titled, "Medication Regimen Review," lacked information regarding the time frames for a pharmacist response, urgent and non-urgent medication recommendations, or a time frame for a facility response to recommendations. 7/11/24 - A review of the 2567 from Annual and Complaint survey dated 7/14/23 revealed a previous deficiency cited for the facilities MRR policy and lack of time frames for response times. 7/12/24 9:48 AM - An interview with E1 (NHA) confirmed the MRR policy provided was current. The facility failed to update the MRR policy per the Plan of Correction dated 9/6/23 which indicated the facility would revise and update policy. 7/18/24 1:05 PM - Findings were reviewed with E1 (NHA) , E2 (DON), E3 (QA/IP), E4 (Corporate RN) and E7 (ADON) at the exit conference.	F 867	in error. The policy had been revised after annual survey in 2023 and submitted with POC. The policy was revised again and reviewed and adopted by the QAPI Committee on 7/20/2024. QAPI committee members will be educated re: this policy.	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F 880		9/4/24

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F 880	Continued From page 77 §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 must prohibit employees with a communicable disease or infected skin lesions from direct	F 880		

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F 880	Continued From page 78 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: Based on observations, interviews and record review, it was determined that for three (3) (R36, R47 and R461) out of thirty-three (33) reviewed in the investigative sample, the facility failed to ensure a urinary catheter bag was kept off the floor and to ensure staff utilized enhanced barrier precautions (EBP). Findings include: 2023 - A facility policy titled, "Enhanced Barrier Precautions- It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms (MDRO). Enhanced barrier precautions refers to the use of gown and gloves for use (sic) during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g. residents with wounds or indwelling medical devices) ...	F 880	The urinary catheter bag for R36 was positioned off the floor. E8 will be educated on EBP when providing tracheostomy care for R47. E35 will be educated on EBP when providing care for R461. Residents with urinary catheter bags have the potential to be affected. Residents requiring Enhanced Barrier Precautions have the potential to be affected. CQA/IP nurse or designee monitors urinary catheter bags daily for proper positioning. Licensed Nursing staff was educated regarding the use of Enhanced Barrier Precautions with high contact resident care activities.	

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F 880	Continued From page 79 Policy Explanation and Compliance Guidelines: 7. High-contact resident care activities include: ... g. Device care or use: central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes ...." 1. Review of R47's clinical record revealed: 5/27/16 - R47 was admitted to the facility with diagnoses including: traumatic brain injury and tracheostomy status. 5/22/24 - An annual MDS revealed that R47 required tracheostomy care. 5/5/23 - A careplan for R47 revealed enhanced barrier precautions related to presence of tracheostomy last revised on 3/19/24. 7/16/24 1:55 PM - An interview with E3 (QA and IP) confirmed that supplies for enhanced barrier precautions should be stored in plastic containers in the room and extra supplies are stored in the units linen closets. 7/16/24 2:58 PM - An observation of tracheostomy care completed by E8 (LPN Agency) lacked use of enhanced barrier precautions. E8 failed to utilize a gown or face shield during tracheostomy care with R47. R47's room lacked necessary supplies needed for enhanced barrier precautions. 2. Review of R461's clinical record revealed: 6/13/24 12:18 PM - E33 (MD) documented the successful placement of right upper extremity	F 880	Observations of staff providing care to residents on EBP will be conducted by QA/IP to ensure that PPE is utilized based on care provided. Audits will be conducted by QA/IP of residents with urinary catheters to assure privacy bag is present and not laying on floor. Audits will be done weekly for four weeks, then monthly for three months. Results will be reported at QAPI Committee meetings monthly.	

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F 880	Continued From page 80 PICC (peripherally inserted central catheter) line. 6/13/24 - R461 was admitted to the facility. 6/13/24 - E34 (NP) ordered "Assess PICC line site RUE (right upper extremity) area for any signs of infection and notify MD (medical doctor) every shift" in R461's EMR. 6/13/24 - E39 (MD) ordered "Enhanced Barrier precautions: related to PICC line and staph infection 1. Gown. 2. Mask 3. Face shield (if splattering expected to occur) 4. Gloves very shift" in R461's EMR. 7/2/24 - E28 (NP) ordered "piperacillin sod-tazobactam Intravenous solution 4.5 gm - give 4.5 grams IV four times a day related to infection" in R461's EMR. 7/15/24 2:09 PM - During medication administration, E35 (LPN) was observed administering R461's 2 PM Piperacillin IVSS dose wearing only gloves, E35 did not have a yellow gown on. 3. Review of R36's clinical record revealed: 1/26/24 - R36 was admitted to the facility. 2/22/24 - A care plan documented that R36 has an indwelling catheter for neurogenic bladder. 4/3/24 - A physician's order for a foley catheter to straight bag drainage for urinary retention. 7/9/24 - Observations of R36's catheter collection bag lying flat on the floor without a privacy bag while R36 was resting in bed at 10:23 AM and	F 880		

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F 880	Continued From page 81 11:14 AM. 7/10/24 11:31 AM - An observation of R36's catheter collection bag was hooked on the wheelchair and the bottom of the collection bag was dragging along the floor while R36 was being pushed in the wheelchair by E15 (COTA). The catheter collection bag did not have a privacy bag cover. An interview with E15 stated she brought R36 back from the large therapy room located off R36's unit and located near the main facility entrance. E15 immediately got a privacy bag, covered the catheter collection bag and hung it off the floor. 7/12/24 9:44 AM - An observation of R36's catheter collection bag was in a privacy bag but touching the floor. E16 (UM) confirmed the catheter collection bag was touching the floor and stated the privacy bag straps are attached to the bed and it is difficult to keep the catheter collection bag off the floor. E16 then manipulated the privacy bag straps and was able to raise the catheter collection bag off the floor. 7/12/24 12:32 PM - An observation of R36's catheter collection bag lying flat on the floor without the privacy bag straps tied to the bed to keep it raised off the floor. An interview with E16 confirmed the catheter collection bag was on the floor. E16 stated she had the collection bag off the floor, the hooks came off the collection bag earlier and she would try something else. 7/12/24 3:05 PM - An interview with E16 revealed that the collection bag was corrected and they used the hooks on the collection bag to attach to the bed frame.	F 880		

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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 82 7/16/24 12:47 PM - An interview with E3 (QA/IP) revealed that the privacy bags are being evaluated for functionality and they may order different bags. 7/18/24 1:05 PM - Findings were reviewed with E1 (NHA) , E2 (DON), E3 (QA/IP), E4 (Corporate RN) and E7 (ADON) at the exit conference.	F 880		
F 921 SS=D	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to maintain a safe and sanitary environment for staff. Findings include: 7/9/24 12:17 PM - Several pipes in the ceiling area of the clean laundry room were dripping onto the floor and into a trash can that had been placed under a portion of the leaking area. All of the leaking pipes had numerous areas of black staining, which appeared fuzzy in some sections. Three wet and stained towels were on the floor under the areas of the leaks. 7/9/24 1:46 PM - During an interview, E50 (Laundry Staff) confirmed the dripping and standing water and stated that the water had been dripping from the pipes and pooling on the floor for several months. 7/18/24 1:05 PM - Findings were reviewed with	F 921	No residents identified. No residents potentially affected. Pipes in laundry room will be repaired Audits of environmental conditions for safety and sanitation will be conducted monthly by Maintenance Director or designee and results reported monthly to Safety Committee.	9/4/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085037	A. BUILDING _____ B. WING _____	C 07/18/2024

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F 921	Continued From page 83 E1 (NHA), E2 (DON), E3 (QA/IP), E4 (Corporate RN) and E7 (ADON) at the exit conference.	F 921		