DELAWARE HEALTH AND SOCIAL SERVICES

Division of Health Care Quality

Office of Long Term Care Residents Protection

DHSS - DHCQ
261 Chapman Road Suite 200
Newark, DE 19702

STATE SURVEY REPORT

NAME OF FACILITY: Stonegates

DATE SURVEY COMPLETED: December 6, 2024

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced Annual, Complaint and Emergency Preparedness Survey was conducted at this facility from December 3, 2024, through December 6, 2024. The facility census was twenty-nine (29) on the first day of the survey. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census on the first day of the survey was twenty-nine (29). The sample totaled was 16.		
3201	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.0	**Scope**		
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** This requirement is not met as evidenced by the following:		

Provider's Signature Michele Dennis RN Title LNHA Date 12/27/24

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	Cross refer to CMS 2567-L survey completed December 19, 2024: F550, F812, F849, F880 and F943.		

Provider's Signature Michele Dennison Title LNHA Date 12/27/24

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085026	A. BUILDING ______ B. WING ______	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEGATES	**4031 KENNETT PIKE GREENVILLE, DE 19807**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Annual, Complaint, and Emergency Preparedness survey was conducted at this facility from December 3, 2024 through December 6, 2023. The facility census was twenty nine (29) 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, 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 An unannounced Annual, Complaint and Emergency Preparedness Survey was conducted at this facility from December 3, 2024, through December 6, 2024. The facility census was twenty nine (29) on the first day of the survey. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census on the first day of the survey was twenty-nine (29). The sample totaled was 16.	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.	F 550		1/31/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 12/27/2024

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 550	Continued From page 1 §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. §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 a random observation and interview it was determined that four (R13, R15, R17 and R19) residents observed during dining, food service employees utilized gloves while in the dining room to serve residents and nursing staff	F 550	1. Gloves will not be worn during meal times except when appropriate. This was done on 12/6/2024 2. All residents have the potential to be	

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F 550	Continued From page 2 utilized gloves in the dining room to feed residents violating resident's dignity in their home environment. Findings include: 9/25/24 - A significant change MDS documented R17 as dependent for eating and severely cognitively impaired. 10/27/24 - An annual MDS documented R15 as dependent for eating and severely cognitively impaired. 11/10/24 - A quarterly MDS documented R19 as dependent for eating and severely cognitively impaired. 11/20/24 - A significant change MDS documented R13 as dependent for eating and severely cognitively impaired. 12/3/24 12:00 PM - An observation during dining of one E12 (Dietary Aid) was observed wearing gloves in the dining room while delivering plated food to the tables. E4 (ADON), E18 (RN) and E19 (RN) three staff members in the dining room utilized gloves while feeding R13, R15, R17 and R19. 12/3/24 Approximately 12:15 PM - During an interview with E12, E4, E18 and E19 findings were confirmed. It was reported that gloves have been in use for serving and feeding residents since the COVID pandemic. 12/6/24 at 1:00 PM - Findings were reviewed during the exit conferences with E1 (NHA), E2 (DON), and E3 (ADON).	F 550	affected by the deficient practice, while wearing gloves did not detract from the resident dining experience, all staff who assist with dining will not wear gloves 3. All nursing staff will be educated on resident rights and how gloves could be perceived as a violation of resident rights by the DON/Designee.Attachment 1. a. During the pandemic as directives were being provided by the CDC, gloves were to be worn during mealtimes which did help prevent the spread of infection when assisting with resident meals. b. There were no complaints by residents or their representatives while gloves were being worn during meal times. there fore, the facility did not perceive that resident rights were being violated by wearing gloves. The intent was to ensure staff and residents were protected, while feeding food that didn't require a fork, or when the residents' mouth needed to be wiped. c. After discussion with the surveyor who brought the deficient practice to our attention it was decided to not wear gloves, unless appropriate during meal times. d. The DON/Designee will review the change in not wearing gloves with all nursing staff by 1/31/2025. This will allow all staff including PRN staff to be informed of the change. 4. DON/Designee will conduct random rounds during all mealtimes weekly to ensure gloves are note being worn. Rounds will be conducted weekly for	

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F 550	Continued From page 3	F 550	3-months, than quarterly through 2025 until 100% compliance is achieved. Attachment 2	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility failed to ensure food was stored, prepared and served in a manner that prevents food borne illness to the residents. Findings include: 12/3/24 9:30 AM - Observations in the kitchen: - The walk-in refrigerator had opened food items stored in facility containers labeled and dated as follows: tartar 10/8/24, mandarins 11/23/24, and	F 812	1. All items of open product have amended labels created by Ecolab and printer has been reprogrammed to add additional "use by" dates for all consumer products. This was resolved 12/3/2024. 2. All bread is labelled by the manufacturer, and dates are located on the closure tag. And additional label will be assed from the Ecolab printer system to denote the "use by Day".	1/31/25

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F 812	Continued From page 4 cherries 11/18/24. There were no dates to indicate when it should be consumed, sold or discarded. In addition, bread slices and sesame buns located inside did not include any dates. The dry storage area contained a bag of tortilla chips, a bag of grits, and a pan of almonds that were not dated when they were opened or prepared. During the above observation an interview with E10 (Food Service Assistant) confirmed these findings. - The walk-in refrigerator, contained raw animal foods that were not organized and stored separately to prevent contamination of other foods. Raw fish was observed next to a container of red beans and above a container of tomato paste. In addition, raw pork was stored above a container of precooked rice and a container of mushrooms. - The ice machine scoop was observed lying on the counter next to the ice machine outside of its protective container. - The walk-in refrigerator and freezer had a case of water and a large container of ice cream on the floor. During the above observation, an interview with E11 (Dietary Aide) confirmed these findings. 12/3/24 10:00 AM - An observation of the refrigerator next to the ice machine, revealed juice containers were not dated when opened. During the above observation an interview with E12 (Dietary Aide) confirmed the juice containers	F 812	Additional shelving has been ordered to reconfigure the walk-in space to ensure all products are stored correctly. An in-service will be conducted with all kitchen personnel to refresh the cold storage standard. Signage has been added to the pantry area where the ice machine is located, instructing all personnel to re-seat the scoop in the correct storage mechanism. All water which was for staff use only will not be stored in this manner moving forward. An in-service will be conducted with all kitchen staff to ensure this is not a reoccurring issue. All items in the refrigerated space are and will be stored in a six inch elevation from the floor. As noted in the previous comments all opened consumable products will have labels reprogrammed to automatically add use by dates. a. Food was not stored or dated per guideline b. Due to storage space the food was stored incorrectly. New shelving has been ordered to correct the issue as previously noted above. c. The training is being conducted by the Director of Culinary Operations/desingee and will be completed by 1/31/2025 See dietary attachments Audits will be conducted by the Culinary	

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F 812	Continued From page 5 were opened and had not been dated. E12 immediately removed the juice containers. 12/6/24 at 1:00 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (DON), and E3 (ADON).	F 812	Director of Operations/designee. These audits will be conducted weekly for one month, then monthly for three months, then quarterly for six months or until 100% compliance is achieved. Attachment 3	
F 849 SS=D	Hospice Services CFR(s): 483.70(n)(1)-(4) §483.70(n) Hospice services. §483.70(n)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(n)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide.	F 849		1/31/25

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F 849	Continued From page 6 (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms	F 849		

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F 849	Continued From page 7	F 849		

associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions.
(I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility.
(J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation.
(K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff.

§483.70(n)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident.
The designated interdisciplinary team member is

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F 849	Continued From page 8 responsible for the following: (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents.	F 849		

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F 849	Continued From page 9 §483.70(n)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of other documentation, it was determined that for one (R17) out of one resident reviewed for hospice, the facility failed to collaborate with the hospice provider in the development of a written plan of care. Findings include: The Nursing Facility Services Agreement, dated 1/27/17, stated: "1.i Hospice and Facility will jointly develop and agree upon a coordinated, interdisciplinary plan of care ... The plan of care will identify which provider is responsible for performing the respective functions that have been agreed upon and included in the Plan of Care... 2.d.ii Facility shall ensure that each hospice patient's care plan includes both the most recent Hospice Plan of Care and a description of the Facility Services furnished by the Facility to attain or maintain the Hospice Patient's highest practicable physical, mental and psychosocial well-being as required by federal regulations." Review of R17's clinical record revealed: 9/18/24 - R17 was admitted to hospice with a diagnosis of cerebrovascular disease.	F 849	1. The facility maintains the hospice nurse along with other services does see the resident based on the hospice schedule. The care plan has been updated to reflect hopsice interventions on the facility care plan as 12/10/24/ The order to monitor for pain was placed in the record on 12/26/24 2. All residents receiving hospiceservices have the potential to be affected by the deficient practice. Those residents receiving hospice have had audits of visits, orders for monitoring pain and care plans reviewed on: 12/10/2024 -12/16/24. Attachment 4 3. All licensed staff will be inserviced by the DON/Designee oncare planning hospice services, ensuring orders to monitor pain are in place and to document each encounter with the hospice nurse when visiting the resident. Attachment 4 a. Both the facility and hospice have care plans for the resident receiving hospice services. b. It was not known that the facility whoudl have the hospice interventions included in	

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F 849	Continued From page 10 R17's facility hospice care plan, initiated on 9/17/24, included the following interventions: -Comfort measures as indicated (back rubs, turning and repositioning); -O2 (oxygen) if indicated...; -d/c (discontinue) weights; -DNR (do not resuscitate); -Monitor for s/sx (signs/symptoms) of pain; -Provide emotional support as indicated; and -Provide spiritual support as indicated. 11/13/24 - Review of R17 ' s current Hospice Provider ' s care plan documented the following interventions: -Hospice nurse to assess effectiveness of cardiopulmonary symptom relief measures including oxygen treatment and comfort modalities; -Hospice nurse to instruct regarding cardiopulmonary symptom relief measures; -Hospice nurse to instruct regarding the safe use of oxygen and monitor its effectiveness; -Hospice nurse to coordinate plan of care with facility staff; -Hospice nurse to provide instructions/reinforcement related to urinary continence; -Hospice nurse for assessment of patient safety, instruct safety measures as applicable; -Hospice nurse to obtain O2 sats via pulse oximeter prn; -Hospice nurse to assess medication response and instruct on schedule, actions, purpose, side effects, compliance and need to report side effects to hospice staff; -Hospice nurse to assess for signs/symptoms of anxiety/terminal agitation and provide instruction	F 849	the facility plan of care. c. The DON/Designee will review the importance of adding the hopsice interventions to the facility care plan making this a more interdisciplinary approach to the resident receiving hospice services. 4. DON/desingee will conduct audits on hopsice visits, care planning and pain orders. They audits will be conducted weekly for one month, then monthly for three month, then quarterly for 6 months or until 100% compliance is achieved. Attachment 5 and Attachment 6	

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	085026	A. BUILDING ______ B. WING ______	C 12/06/2024

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F 849	Continued From page 11 regarding origin and management; -Chaplain to evaluate patient/family/caregiver and develop a plan of care; -Medical social worker to evaluate social, emotional and financial factors related to the patient's illness. Need for additional care/resources, adjustment to care and develop a plan of care; -Home Health Aide service for assistance with personal are, hygiene and activities of daily living. The facility failed to ensure that the current Hospice Provider ' s care plan approaches were included in R17 ' s facility ' s care plan. There was no order in R17's electronic medical record to monitor for pain at scheduled intervals. A review of R17's electronic medical record between 9/18/24 and 12/6/24 revealed only one instance (11/13/24) of Facility staff contacting Hospice regarding R17's change in condition where they presented with labored breathing and crackles (an abnormal lung sound). A review of R17's electronic medical record, dated 11/14/24, revealed that the lab contacted the Facility regarding critical lab values (BNP 1318) (BNP or B-type natriuretic peptide test is a blood test that indicates how well or how poorly the heart is working. Higher BNP levels can indicate heart failure and a normal BNP level for someone over age 75 is 450 pg/ML). R17's chart reveals a call placed by the Facility nurse to the primary care physician who provided new orders. There was no evidence in R17's electronic medical record that the Hospice Provider was made aware of this lab result.	F 849		

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F 849	Continued From page 12 11/26/24 - The Hospice IDG (Interdisciplinary Group) Comprehensive Assessment and Plan of Care Update Report documented that the Hospice RN visited R17 on 9/18/24, 11/13/24, 11/14/24 and 11/20/24. The facility lacked evidence of communication between the Hospice RN and the facility staff in R17's electronic medical record. There was no evidence that the Hospice nurse provided any of the education outlined in the hospice care plan to facility staff. 12/4/24 at approximately 1:30 PM - An observation of resident's hospice binder located in the nurse's station revealed the absence of a sign in sheet for hospice staff (Hospice RN, Home Health Aide, or Medical Social Worker) between 9/18/24 through 12/6/24 and the absence of the latest Hospice IDG Comprehensive Assessment and Plan of Care Update Reports. 12/4/24 at approximately 2:00 PM - During an interview, E3 (ADON) revealed that "the hospice nurse usually comes on Thursdays, but they don't check in with us and sometimes if there is a replacement, we don't know they have been here and we have to call them to ask if the hospice nurse is coming. The nurse aide comes weekly, but their schedule changes and we can't wait for them to do care, so they just assist facility staff as they can." 12/4/24 at approximately 2:15 PM - During an interview, E10 (LPN) stated, "we talk to the hospice nurse about the resident's status when she comes, but we don't chart that." 12/5/24 - In response to the Surveyor's request with the facility management, the Hospice	F 849		

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F 849	Continued From page 13 Provider furnished the Hospice IDG Comprehensive Assessment and Plan of Care Update Reports from 11/12/24 and 11/26/24. 12/6/24 at 1:00 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (DON) and E3.	F 849		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 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	F 880		1/31/25

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F 880	Continued From page 14 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 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 observation and interview it was determined that for two random observations of	F 880	1. The door from the washer room to the dryer room was kept shut as of 12/6/2024.	

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F 880	Continued From page 15 the laundry room, the facility failed to handle, store and process linens to prevent the spread of infection. 12/4/24 9:30 AM - The following was observed in the laundry area: - The door from the washer room to the dryer (clean) room was open. -The room with the washing machines had blue rags on the floor to the right of the washer and a cell phone was plugged in and laying on top of a washer. -The soiled room contained an office desk, resident emergency water supply, a cell phone on the desk and a cart with clean linen that had a cover on it. 12/4/24 9:35 AM - In an interview E16 (Laundress) confirmed the door was open. 12/4/24 9:45 AM - In an interview with E14 (Supply Supervisor), the open doors were discussed and it was confirmed that the door between the soiled and clean are to be closed at all times. 12/05/24 8:32 AM - The following was observed in the laundry area: - The door from the washer room to the dryer (clean) room was propped open with a large linen cart. - The soiled room contained an office desk, small bag of soiled laundry, resident emergency water source and clean linen that had a cover on it.	F 880	2. All residents have the potential to be affected by the deficient practice. All food items have been removed, the water has been discarded and replaced with new water which is kept in the dietary storeroom as of 12/20/24. 3. All laundry personnel will be inserviced on proper prevention infection and the importance of keeping the door closed between the washer and dryer room. not to store anything in the dirty or clean areas and no personal belongings or food stuff can be in the area. Attachment 11 a. It was determined that the staff of the laundry had a lack of understanding regarding the importance of infection prevention related to the dirty/ clean area of the laundry. b. The area has been cleared of all items that are prohibited. c. The training will be completed by 1/31/2025. 4. Random audits will be conducted by the Laundry Supervisor/Designee on a weekly basis including weekends and holidays for one month, then monthly for three months and then quarterly for 6 months or until 100% compliance is achieved. Attachment 7	

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F 880	Continued From page 16 12/5/24 8:35 AM - In an interview E17 (Laundress), confirmed the location of the soiled linen room and the contents. The stack of residents emergency water source and a cart of covered clean linen that is not used anymore. 12/6/24 12:15 PM - During an interview and observation with with E14 of the open laundry room doors, emergency water source for residents and the cart containing the clean linen it was confirmed that the doors between clean and soiled can not be open and the water and clean linen can not be stored in the soiled linen room. 12/6/24 at 1:00 PM - Findings were reviewed during the exit conferences with E1 (NHA), E2 (DON), and E3 (ADON).	F 880		
F 943 SS=D	Abuse, Neglect, and Exploitation Training CFR(s): 483.95(c)(1)-(3) §483.95(c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- §483.95(c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. §483.95(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property §483.95(c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced	F 943		1/31/25

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F 943	Continued From page 17 by: Based on interview and review of other facility documentation it was determined that the facility failed to ensure that two (E13 and E14) out of five sampled employees received training on dementia management. Findings include: Review of facility training records for dementia training revealed two staff members without evidence of dementia training: - E13 was hired on 8/19/15. The facility lacked evidence of dementia training for E13. - E14 was hired on 3/28/18. The facility lacked evidence of dementia training for E14. 12/5/24 PM - An interview with E15 (HR Director) confirmed that the above two employees did not have the required dementia training. 12/6/24 at 1:00 PM - Findings were reviewed during the exit conferences with E1 (NHA), E2 (DON) and E3 (ADON).	F 943	1. Dementia training was completed on 12/10/2024 Attachments 8 and 8.1 2. All staff who access the health center will have their HR files audited for Dementia training. 3. Dementia training will be provided for all staff who may not have completed the training based on the audit. Attachment 9 a. The Dementia training for the two staff members was overlooked, there was a lack of perceived importance that all staff not just health care staff have training and information on Dementia. b. All department managers are responsible to ensure annual training is being conducted, for all employees. The Administrator/designee will ensure the Dementia training is reviewed annually with each department. 4. Training for Dementia will be audited monthly to include current and new staff who access healthcare. This audit will be ongoing for one year or until 100% compliance. The audit will be conducted by the LNHA/designee. Attachment 10	