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

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

STATE SURVEY REPORT

NAME OF FACILITY: Westminster Village Health

DATE: SURVEY COMPLETED: October 31, 2024

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	An unannounced Annual, Complaint and Emergency Preparedness survey was conducted at this facility from October 21, 2024, through October 31, 2024. The deficiencies contained in this report are based on observation, interviews, review of clinical records and other facility documentation as indicated. The facility census on the first day of the survey was fifty-nine (59). The survey sample size was eighteen (18) residents.		
3201	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.0	**Scope**		
3201.1.1	**A Nursing facility (NF) is a residential institution, as defined in 16 Delaware Code §1102(4), which provides services to residents which include resident beds, continuous nursing services, and treatment services for individuals who do not currently require continuous hospital care. Care is given in accordance with a physician's orders and requires the competence of a registered nurse (RN).** This requirement is not met as evidenced by the following: Cross Refer to the CMS 2567-L survey completed October 31, 2024: cross refer: F641 F657, F684, F690, F756, F803, and F812.	Cross Refer to the CMS 2567-L survey completed October 31, 2024: cross refer: F641 F657, F684, F690, F756, F803, and F812.	
§ 1141 Subchapter IV Criminal background checks.	**(c) No employer may employ an applicant for work in a facility before obtaining a criminal history. The criminal history of any person not directly employed by the facility must be provided to the facility upon the person's commencement of work.**		12/09/2024

Provider's Signature Isaiah Shaw Title LNHA Date 11/20/2024

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	Based on review of facility documentation and interview, it was determined that the facility failed to obtain the criminal history from the Background Check Center (BCC) and fingerprinting for one (E17) out of 10 randomly sampled employees (agency and facility staff) prior to start of employment or assignment. Findings include: 2/12/24 – E17 (Therapist) first day in the facility. 10/25/24 - Review of the State Agency Personnel Audit Form completed by the facility revealed that E17's Background Check for adult, child and fingerprinting were left blank. 10/28/24 – An interview with E1 (NHA) revealed that the facility was having difficulty obtaining Background Check and fingerprinting information from a contracted agency for the therapy department. E1 stated she was in contact with the state's BCC (Background Check Center) and would update when she received the data. At this time E1 stated she would be offering therapy via telehealth till the data was received. 10/31/24 9:00 AM – A desk review of the state database verification revealed that E17 was not registered in the state's BCC (Background Check Center) under the contracted agency (agency name) and that the BCC did not have a record of E17's adult and child abuse registry verification and fingerprinting. 10/31/23 10:13 AM – After consultation with the State Agency employee who analyzed the Personnel Audit form completed by the facility, E1 (ED) was notified by this surveyor that E17, without fingerprinting	**§ 1141** **Subchapter IV** **Criminal background checks.** E17 does not currently work at this facility. All therapy staff records have the potential to be affected, and therapy was provided via tele-health during this review period. All therapy staff criminal background records have been received and are compliant with the BCC requirements. A root cause analysis revealed the need for a contract addendum change with the therapy company. A Corporate Compliance Addendum (CCA) was updated and signed by the therapy company acknowledging the requirement for Executive Director notification of new therapy staff and for all therapy staff and to provide evidence of criminal background and history upon commencement of work. Once received, the Executive Director will be responsible for reviewing and verifying the documents and approving all new therapy staff to work at this facility.	12/09/2024

Provider's Signature Lisa Shaw Title LNHA Date 11/20/2024

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	and Background Check results (adult and child), could not continue to work until fingerprinting and adult/child registry verification were completed. E1 stated she would contact the involved staff and take her off the schedule. Findings were discussed and reviewed with E1 (NHA), E2 (DON) and E4 (ED) on 10/31/24 at 3:00 PM.	The ED/designee will conduct an audit of all newly hired therapy staff to ensure criminal background evidence is received upon commencement of work. These audits will be conducted daily x5 days until 100% compliance is verified, then weekly x4 weeks until 100% compliance is verified, then monthly x3 months until 100% compliance is verified. Results will be presented to the Quality Assurance Process Improvement team for review and recommendation	12/09/2024

Provider's Signature Nathan Allen Title LNHA Date 11/20/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085032	A. BUILDING _____ B. WING _____	C 10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMINSTER VILLAGE HEALTH	1175 MCKEE ROAD DOVER, DE 19904

(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 and complaint survey was conducted at this facility from October 21, 2024 through October 31, 2024. The facility census was 59 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 An unannounced annual and complaint survey was conducted at this facility from October 21, 2024 through October 31, 2024. The deficiencies contained in this report are based on observation, interviews, review of clinical records and other facility documentation as indicated. The facility census on the first day of the survey was fifty-nine (59). The survey sample size was eighteen (18) residents. Abbreviations/definitions used in this report are as follows: ADON - Assistant Director of Nursing; CNA - Certified Nursing Assistant; DON - Director of Nursing; LPN - Licensed practical nurse; MAR - Medication Administration Record; MD - Medical Director; MDS - Minimum Data Set; NHA - Nursing Home Administrator; NP - Nurse Practitioner;	F 000		

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

Electronically Signed | 11/20/2024

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 RN - Registered nurse; SW - Social Worker; UM - Unit Manager. Activities of daily living (ADLs) - tasks needed for daily living, e.g. dressing, hygiene, eating, toileting, bathing; AIMS (Abnormal Involuntary Movement Scale) - a rating scale to measure involuntary movements of the face, mouth, trunk, or limbs known as tardive dyskinesia that sometimes develops as a side effect of long-term treatment with antipsychotic medications; Brief Interview for Mental Status (BIMS) - assessment of the resident's mental status. The total possible BIMS Score ranges from 0 to 15 with 15 being the best. 0-7: Severe impairment (never/rarely made decisions) 08-12: Moderately impaired (decisions poor; cues/supervision required) 13-15: Cognitively intact (decisions consistent/reasonable); dL - deciliter; Medication Administration Record (MAR) - list of daily medications to be administered; ml: milliliter; Minimum Data Set assessment (MDS) - Federally mandated comprehensive, standardized, clinical assessment of all residents in Medicare/Medicaid nursing homes that evaluates functional capabilities and health needs; Medication Regimen Review (MRR) - monthly review by pharmacist of resident's medications, laboratory tests and any records necessary to determine whether or not irregularities exist; Preadmission Screening and Resident Review (PASARR) - screening for evidence of serious mental illness and/or intellectual disabilities,	F 000		

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F 000	Continued From page 2 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; PRN - as needed; Treatment Administration Record (TAR) - list of daily/weekly/monthly treatments to be performed.	F 000		
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 interviews, it was determined for three (R16, R32, and R217) out of eighteen residents in the investigative sample, the facility failed to ensure the MDS was accurate. Findings include: 1. Review of R16's clinical record revealed: 9/28/24 - R16 was admitted to the facility. 10/4/24 - An admission MDS documented that R16 had restraints. These restraints included bilateral bed rails. 10/21/24 - An observation of R16 in bed with bilateral side rails in place, used as an enabler bar for turning and repositioning. 10/25/24 1:48 PM - An interview with E6 (RNAC), E7 (RNAC) and E1 (NHA) revealed that the MDS was miscoded for R16 and discovered when surveyors requested the Matrix. E1 stated that E7	F 641	R16 still resides in the facility. R32, and R 217 no longer reside in the facility. Side rails are used as enabler bars for turning and repositioning in bed. Modifications were made to R16, R32 and R17□s MDS to reflect enabler bars and not restraints. Current residents residing in the facility using side rails as enabler bars have the potential to be affected by this practice. MDS records for current residents with enabler bars were audited to ensure no others were coded with restraints. No other miscoding was found. A root cause analysis revealed the need for re-education on the coding of residents with enabler bars being used to assist with turning and reposition while in bed. Resident Nurse Assessment Coordinator will be re-educated by Administrator or designee on verifying that information is	12/9/24

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F 641	Continued From page 3 is in training and miscoded the MDS. E1 provided evidence that the MDS was corrected. 2. Review of R32's clinical record revealed: 10/2/24 - R32 was admitted to the facility. 10/4/24 - An admission MDS documented that R32 had restraints. These restraints included bilateral bed rails. 10/22/24 - An observation of R32 in bed with bilateral side rails in place, used as an enabler bar for turning and repositioning. 10/25/24 1:48 PM - An interview with E6 (RNAC), E7 (RNAC) and E1 (NHA) revealed that the MDS was miscoded for R32 and discovered when surveycrs requested the Matrix. E1 stated that E7 is in training and miscoded the MDS. E1 provided evidence that the MDS was corrected. 3. Review of R217's clinical record revealed: 9/20/24 - R217 was admitted to the facility. 9/26/24 - An admission MDS documented that R217 had restraints. These restraints included bilateral bed rails. 10/22/24 - An observation of R217 in bed with bilateral side rails in place, used as an enabler bar for turning and repositioning. 10/25/24 1:48 PM - An interview with E6 (RNAC), E7 (RNAC) and E1 (NHA) revealed that the MDS was miscoded for R217 and discovered when surveyors requested the Matrix. E1 stated that E7 is in training and miscoded the MDS. E1 provided	F 641	accurately coded in the MDS. Resident Nurse Assessment Coordinator/designee will conduct an audit of current residents with enabler bars to ensure to ensure each assessment is accurately coded on the MDS. Audits will be conducted daily X5 days until 100% compliance is verified, then weekly X 4 weeks until 100% compliance is verified, then monthly X 3 months until 100% compliance is verified. Results will be presented to the Quality Assurance Performance Committee for review and recommendations.	

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F 641	Continued From page 4 evidence that the MDS was corrected. 10/31/24 3:00 PM - Findings were reviewed with E1 (NHA) , E2 (DON), and E4 (Executive Director) at the exit conference.	F 641		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was	F 657	R 37 no longer resides in the facility. All	12/9/24

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F 657	Continued From page 5 determined that for one (R37) out of eighteen residents reviewed in the investigative sample, the facility failed to ensure that the required interdisciplinary team (IDT) members participated in the care plan meetings. Findings include: Review of R37's clinical record revealed: 10/3/24 - R37 was admitted to the facility. 10/16/24 - A careplan meeting interdisciplinary note revealed that the following attendees were present: R37, family member, nursing, therapy, CNA, Social worker, and dietary. 10/25/24 9:22 AM - An interview with E6 (RNAC) confirmed that physician or physician's representative did not participate in R37's care plan conferences. E6 stated the physician reviews residents monthly but not in coordination with the care plan meetings. 10/31/24 3:00 PM - Findings were reviewed with E1 (NHA) , E2 (DON), and E4 (Executive Director) at the exit conference.	F 657	required members of the interdisciplinary team (IDT) participate in care plan meetings. All professional disciplines, as determined by the resident□s needs or as requested by the resident also attend care plan meetings. Current residents residing in the facility have the potential to be affected by this practice. Care plan notes from the past 30 days have been audited to ensure that required team members were present at the meetings. A root cause analysis revealed the need for re-education on the requirement of physicians to attend care plan meetings. The Medical Director will be re-educated by the Administrator/designee on the requirement of attending care plan meetings. The Resident Nurse Assessment Coordinator/designee will conduct an audit of care plan meeting notes in the past 14 days to ensure required team members were in present. Audits will be conducted daily X 5 days until 100% compliance is verified, then weekly X 4 weeks until 100% compliance is verified, then monthly X 3 months until 100% compliance. Results will be presented to the Quality Assurance Performance Committee for review and recommendations.	
F 684 SS=D	Quality of Care CFR(s): 483.25	F 684		12/9/24

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F 684	Continued From page 6 § 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 two (R1 and R27) out of six residents reviewed for unnecessary medication review, it was determined that the facility failed to follow physician orders. Findings include: 1. Review of R1's clinical record revealed: 10/22/18 - R1 was admitted to the facility with diagnoses including diabetes mellitus. 8/12/21 - A physician's order documented Lantus 100 units/ml, administer 30 units subcutaneously in the evening (hold for finger stick blood sugar less than 100). 2/17/24 4:01 PM - Review of the MAR revealed R1's glucose was 78 ml/dl. Although R1's glucose was less than 100, E5 (LPN) administered the Lantus. 10/24/24 11:41 AM - During an interview, E5 (LPN) revealed if the doctor writes a parameter to hold insulin for low blood sugars, then E5 holds the insulin. E5 further revealed if the blood sugar was excessively high or low, the doctor is notified and then E5 would document the blood sugar level in the MAR.	F 684	R1 and R 27 still reside in the facility. Lantus and Midodrine with parameters are being administered according to physician orders. Current residents residing in the facility with orders for Lantus and Midodrine with parameters have the potential to be affected by this practice. All active physician orders of Lantus with parameters and Midodrine with parameters were audited to ensure physician orders are being followed and the medications are being administered according to the prescribed parameters. A root cause analysis revealed the need for re-education on following physician orders for medications with parameters. The license nurses will be re-educated by the DON/designee on following physician orders when administering medications with parameters. The DON/designee will conduct an audit of all active physician orders of Lantus with parameters and Midodrine with parameters to ensure parameters are	

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F 684	Continued From page 7 10/24/24 12:17 PM - An interview with E3 (LPN) confirmed that she documented a blood sugar of 78 and that Lantus 30 units was administered subcutaneously. 2. Review of R27's clinical record revealed: 12/5/22 - R27 was admitted to the facility. 12/21/22 - A physician's order was written for "midodrine HCL 2.5 mg one tablet by mouth three times a day before meals. Alert please note parameters: hold for systolic blood pressure (SBP) greater than 130." 11/2023 - A review of the November 2023 MAR revealed that on 11/5/23 R27 documented a blood pressure listed of 152/81 and a signature indicating midodrine medication was administered. 11/1/23 - 11/16/23 - A consultant pharmacist's medication regimen review documented that R27 recommendation to "read parameters closely for holding midodrine. Order is to hold midodrine for SBP greater than 130 but dose is documented as administered on November 5 at 9:00 AM when blood pressure is 152/81." 10/24/24 2:31 PM - An interview with E14 (LPN) confirmed that midodrine was signed off on 11/5/23 at 9:00 AM, even though parameters indicated to not administer. The facility lacked evidence that the aforementioned irregularity was addressed. The progress notes lacked evidence of monitoring related to medication being administered outside	F 684	being followed. Audits will be conducted daily X 5 days until 100% compliance is verified, then weekly X 4 weeks until 100% compliance is verified, then monthly X 3 months until 100% compliance. Results will be presented to the Quality Assurance Performance Committee for review and recommendations.	

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F 684	Continued From page 8 of the parameters. 10/31/24 3:00 PM - Findings were reviewed with E1 (NHA) , E2 (DON), and E4 (Executive Director) 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 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	F 690		12/9/24

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F 690	Continued From page 9 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 (R21 and R37) out of two residents reviewed for incontinence, the facility failed to provide services to restore bowel and bladder continence. Findings include: 1. Review of R21's clinical record revealed: 12/22/23 - A policy titled "Bowel and Bladder training" documented the "objective is to retrain a formerly continent resident or reduce incontinence in residents with stress or urge incontinence. ...Procedure "1. determine eligibility for retraining program using the Bowel and Bladder UDA. A bowel or bladder UDA is assigned with each new admission, quarterly, annually and with each resident significant change. Upon completion the bowel and bladder evaluation is reviewed to determine if voiding diaries are needed in order to ascertain resident toileting plans. .... 3. Establish scheduled toileting program. 4. Determine appropriate incontinence aids to assist in obtaining continence. ... 6. Establish an individualized bowel or bladder program for each resident. 7. Place approaches on the individual resident's care plan." 8/29/24 - R21 was admitted to the facility. 8/29/24 6:40 PM - A bowel and bladder evaluation documented that R21 was totally dependent for toileting with one staff assistance. It also	F 690	R 21 and R 37 no longer reside in the facility. A 3-day voiding and bowel movement diary is utilized to evaluate residents with a decline in bowel and bladder function, to determine eligibility for continence retraining. All residents have the potential to be affected. An audit was conducted on all current residents with a bowel and bladder function decline to ensure that an individualized intervention was implemented to restore continence. No other residents were identified. A root cause analysis revealed the need for re-education for the Nursing Assessment Coordinators (RNAC and LNAC) and all licensed nursing staff on initiating a 3-day voiding and bowel movement diary upon admission, quarterly and with any decline in the resident□s continence pattern. Root cause analysis also revealed the need for re-education of the C.N.As on following resident□s individualized toileting plan. The education will be provided by the Administrator/designee. The Nursing Assessment Coordinators (RNAC and LNAC) will conduct an audit of all current residents with a decline in bowel and bladder function to ensure that	

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F 690	Continued From page 10 documented that R21 had an indwelling catheter and frequently incontinent of bowel. 8/30/24 - A care plan was initiated for R21 for continence issues with a goal to regain bowel control within ninety days. Interventions were to assist R21 with bedpan use upon rising, before and after meals, at bedtime and every two hours on overnight shift; use of incontinence products; and voiding diary as needed. 8/2024 - The CNA task flow sheet for August 2024 revealed that R21 was incontinent of bowel two times. R21 was continent of bowel one time. The CNA flow sheet lacked evidence of following the individualized interventions for R21 listed in the care plan. The flow sheet documented bowel function, control, appliances, and consistency every shift. 9/2024 - The CNA task flow sheet for September 2024 revealed that R21 was incontinent of bowel seventeen times. R21 was continent of bowel three times. The CNA flow sheet lacked evidence of following the individualized interventions for R21 listed in the care plan. The flow sheet documented bowel function, control, appliances, and consistency every shift. 9/4/24 - An admission MDS assessment documented R21 was dependent for toileting with one staff assistance. The MDS also documented that R21 was always incontinent of bowel and that R21 was not on a toileting program. 10/2024 - The CNA task flow sheet for October 2024 revealed that R21 was incontinent of bowel seventeen times. R21 was continent of bowel zero times. The CNA flow sheet lacked evidence	F 690	an intervention was initiated to determine eligibility for bladder or bowel retraining to restore bladder and bowel function. The audits will be conducted daily X 5 days until 100% compliance is verified, then weekly X 4 weeks until 100% compliance is verified, then monthly X 3 months until 100% compliance	

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F 690	Continued From page 11	F 690		

of following the individualized interventions for R21 listed in the care plan. The flow sheet documented bowel function, control, appliances, and consistency every shift.

10/21/24 10:56 AM - In an interview R21 stated that she uses a bedpan and is able to verbalize the need for elimination. R21 stated that prior to admission she used the toilet until her increased difficulty walking.

10/24/24 11:04 AM - In an interview with E15 (NP) stated that the expectation is for nurses and CNA's to monitor for changes in continence and report changes to the provider if any occur.

10/24/24 11:35 AM - In an interview with E14 (LPN) revealed that the facility does not have a set toileting program and that staff should be consistently monitoring resident's for bowel and bladder changes. E14 indicated that the CNA's do "check and change" every two hours and that is the toileting program. E14 stated that R21 is not on a toileting program other than the every two hours check and change.

10/29/24 1:40 PM - During an interview, E16 (CNA) stated that R21 does not use a bed pan and that she does not offer one to R21.

There was no evidence that the facility attempted to restore bowel function for R21.

2. Review of R37's clinical record revealed.

10/3/24 - R37 was admitted to the facility.

10/3/24 - A care plan was initiated for R37 to remain continent of bowel and bladder through

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F 690	Continued From page 12	F 690		

ninety days with interventions of using incontinence products (briefs, fracture pan), voiding diary as needed, and assist to bedpan/ toilet per request.

10/9/24 - An admission MDS documented R37 was dependent for toileting with one assist, frequently incontinent of bladder and always incontinent of bowel.

10/2024 - The CNA task flow from 10/3/24 to 10/31/24 documented R37 was incontinent of urine fifty four times out of eighty four opportunities, which was 63% of the time throughout the month. R37 was continent of urine seven times. The CNA flow sheet lacked evidence of following R37's individualized interventions listed in the care plan. The CNA flow sheet documented bladder function, voiding, toilet use or appliances, incontinence products, and control.

10/21/24 1:40 PM - An interview with R37 revealed that she is continent and able to voice when she has to use the bathroom. R37 stated that at times she becomes incontinent waiting for staff assistance to the toilet.

10/24/24 11:35 AM - During an interview, E14 (LPN) revealed that the facility does not have a set toileting program and that staff should be consistently monitoring resident's for bowel and bladder changes. E14 indicated that the CNA's do "check and change" every two hours and that is the toileting program. E14 stated that R37 is not on a toileting program other than the every two hours check and change.

10/29/24 1:40 PM - During an interview, E16

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F 690	Continued From page 13 (CNA) stated that R37 does not use a bed pan and that R37 is not on a toileting program. 10/31/24 3:00 PM - Findings were reviewed with E1 (NHA) , E2 (DON), and E4 (Executive Director) at the exit conference.	F 690		
F 756 SS=C	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.	F 756		12/9/24

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F 756	Continued From page 14 §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to develop policies and procedures for the monthly MRR (Medication Regimen Review) that included time frames for different steps in the MRR process. Findings include: 12/05/23 12:50 PM - A review of the facilities policy titled, "Consultant Pharmacist Reports," lacked information regarding the time frames for a pharmacist response for urgent medication recommendations. The MRR policy did not meet the expected time frame requirements. 10/31/24 - An interview during exit conference with E1 (NHA) confirmed the MRR policy did not meet the expected requirements for urgent medication response times. 10/31/24 9:45 AM - Findings were reviewed with E1 (NHA) , E2 (DON), and E4 (Executive Director) at the exit conference.	F 756	No residents were affected by this practice. The Consultant Pharmacy Report Policy was reviewed and revised to include times frames for different steps in the MRR process. Current residents have the potential to be affected. Pharmacy consultant reports were audited for the last 30 days to ensure no urgent irregularities were identified. None were identified. A root cause analysis revealed the need to revise The Consultant Pharmacy Report Policy to include time frames for different steps the pharmacy consultant will take if he/she identifies an urgent irregularity. A root cause analysis also revealed the need for re-education of the consultant pharmacist on the revised policy. Director of Nursing will conduct monthly audits X 3 months to ensure all urgent irregularities noted were addressed upon identification of irregularity as per the revised policy. Results will be presented to the Quality Assurance Performance Committee for review and	

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F 756	Continued From page 15	F 756	recommendations	
F 803 SS=D	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observation and interviews, it was determined that for one (R47) out of eight residents sampled for food the facility failed to follow menu requests. Findings include: 10/21/24 10:11 AM - A random observation of	F 803	R47 resides at the community and was offered alternative menu items, including those originally indicated on her meal ticket. Current residents have the potential to be	12/9/24

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F 803	Continued From page 16 R47's breakfast tray revealed oatmeal, cheerios, scrambled eggs, raisin toast and hot tea. The meal ticket showed R47 was supposed to have apple juice, oatmeal, fresh whole apple, fried egg, cinnamon wheat toast, 2% milk and coffee or hot tea. The tray was missing apple juice and a fresh whole apple. The meal ticket showed R47's dislikes as: chocolate, gravy, apples, eggs, milk or pork and to serve soft fruits. R47 stated they bring her food that she doesn't like. 10/21/24 10:20 AM - An interview with E8 (CNA) confirmed that R47 did not have apple juice or a substitute and did not have a fresh whole apple or any substitute. E8 stated that there was no apple juice left and offered to give R47 cranberry juice. E8 stated that the kitchen makes up the tray and we bring the trays to the resident rooms. 10/22/24 9:32 AM - A random observation of R47's breakfast tray revealed cranberry juice, cheerios, bacon, sausage and hot tea. The meal ticket showed R47 was supposed to have apple juice, cream of wheat, fresh whole orange, scrambled eggs with onions, wheat toast, 2% milk and coffee or hot tea. The tray was missing a fresh whole orange and scrambled eggs with onions. The meal ticket showed R47's dislikes as: chocolate, gravy, apples, eggs, milk or pork and to serve soft fruits. R47 stated that she cannot eat pork and would not be able to eat the bacon or the sausage and would only eat the cheerios. 10/22/24 9:37 AM - An interview with E9 (RN) confirmed that R47 did not have a fresh orange or a substitute and confirmed the rest of the items on the breakfast tray. E9 offered sliced oranges to give to R47. E9 confirmed that R47's dislike of pork on the meal ticket and that R47 received	F 803	affected by this practice. Meal tickets were monitored for other residents with no errors identified. A root cause analysis revealed the need for re-education on meal ticket accuracy when plating food. Dining staff who are assigned to follow the meal ticket and plate food will be re-educated by the Dining Director/designee on menu ticket accuracy. The Dining Director/designee will conduct an audit of all residents meal tickets to ensure accurate plating. Audits will be conducted daily X 5 days until 100% compliance is verified, then weekly X 4 until 100% compliance is verified, then monthly X 3 until 100% compliance is verified. Results will be presented to the Quality Assurance Performance Committee for review and recommendations	

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F 803	Continued From page 17 bacon and sausage. 10/23/24 10:03 AM - An interview with E10 (Dietary Regional Support) revealed that the kitchen staff follow the meal ticket and plates the items according to the meal ticket. If a food item is a disliked item, it is not to be plated on the tray. If something is not available, we are to offer a substitution of the same nutritional value. E10 stated that the staff who plated R47's tray was filling in from the independent living side and had not plated trays before. 10/23/24 10:21 AM - An interview with E11 (Dietician) confirmed that if a food item is not available a substitute that is nutritionally equivalent is needed. 10/31/24 3:00 PM - Findings were reviewed with E1 (NHA) , E2 (DON), and E4 (Executive Director) at the exit conference.	F 803		
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 gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents	F 812		12/9/24

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F 812	Continued From page 18 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: 10/21/24 9:14 AM - During the initial tour of the kitchen, there were no buckets containing sanitizing solution for storing wet wiping clothes used for sanitizing food preparation surfaces. 10/21/24 9:38 AM - During a tour of the kitchen, E12 (Cook) tested the sanitizing solution in the three compartment sink, directly at the source two times. Both attempts indicated the level of chemical concentration was not at a sufficient level to provide proper sanitization. An interview with E12 later that day revealed the facility had been using the incorrect type of chemical test strips when testing the sanitizer levels in the kitchen. 10/21/24 9:42 AM - During a tour of the kitchen, there were three compromised food cans with dented sides, which were not separated from the cans of food being served to the residents. 10/21/24 10:23 AM- During a tour of the kitchen, the ice scoop was being stored inside the ice machine laying on top of the ice exposing the ice to contaminants from the handle.	F 812	No residents were affected by this practice. The sanitizing solution and buckets were prepared and put in place. The correct chemical test strips were obtained and used. The incorrect chemical test strips were disposed of. The cans with dented sides were removed from the building. There were no other dented cans identified. The ice scoop was removed from the ice machine, ice in the machine was disposed of and the machine was sanitized. The facility cannot correct past dated temperature logs All residents have the potential to be affected by this practice. The sanitizing solution and buckets were put in place. The correct chemical test strips were put in place. The incorrect chemical test strips were disposed of. The dented cans were removed. The ice scoop was removed, ice from the machine removed and ice scoop and machine were sanitized. The temperature log sheets were completed going forward. A root cause analysis revealed the need for re-education of the Dietary staff regarding the sanitizing solution and bucket, correct chemical test strip, proper handling of dented cans, proper ice scoop	

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F 812	Continued From page 19 10/21/24 11:35 AM During a review of the food temperature logs, the facility kitchen records had no food temperatures recorded for twenty-three (23) meals out of three-hundred thirty-six (336) meals sampled. Temperatures of cooked foods and cold ready to eat foods were not being consistently recorded prior to being served. Fish, meat, and poultry must be heated to an appropriate specific temperature depending on the type of food and the method used to prepare it. Vegetables must be heated to one hundred thirty-five (135) degrees Fahrenheit (F), and cold ready to eat foods must be held below forty-one (41) degrees (F) to maintain food safety. 10/21/24 3:23 PM - Findings were confirmed with E12 (Cook). 10/31/24 3:00 PM - Findings were reviewed with E1 (NHA) , E2 (DON), and E4 (Executive Director) at the exit conference.	F 812	procedures and temperature log completion. The Director of Dining Services will re-educate the Dietary staff regarding sanitizing solution and bucket, correct chemical test strips, proper handling of dented cans, proper ice scoop procedures and temperature log completion. The Director of Dining Services/designee will conduct an audit of the sanitizing solution and bucket, correct chemical test strip, proper handling of dented cans ice scoop procedures and temperature log completions. These audits will be conducted daily x5 days until 100% compliance is verified, then weekly x4 weeks until 100% compliance is verified, then monthly x3 months until 100% compliance is verified. Results will be presented to the Quality Assurance Process Improvement team for review and recommendation.	