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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	085028		10/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES - WILMINGTON	700 FOULK ROAD WILMINGTON, DE 19803

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E 000	Initial Comments	E 000		
	An unannounced annual survey was conducted at this facility from September 20, 2018 through October 2, 2018. The facility census the first day of the survey was 120. During this period, an Emergency Preparedness survey was also conducted by the State of Delaware Division of Health Care Quality, Office of Long Term Care Residents Protection in accordance with 42 CFR 483.73.			
	For the Emergency Preparedness survey, no deficiencies were identified.			
F 000	INITIAL COMMENTS	F 000		
	An unannounced annual and emergency preparedness survey was conducted at this facility from 9/20/18 through 10/2/18. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census the first day of the survey was 120. The survey sample size was 47.			
	Abbreviations/definitions used in this report are as follows: ADLs - Activities of Daily Living/basic self-care tasks; include feeding, toileting, selecting proper attire, grooming, maintaining continence, putting on clothes, bathing, walking and transferring (such as moving from bed to wheelchair); ADON - Assistant Director of Nursing; Amputation - removal of a limb; Antipsychotic- class of medication used to manage psychosis, an abnormal condition of the mind involving a loss of contact with reality and other mental and emotional conditions; Autoimmune thyroiditis - also called Hashimoto's			

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

Electronically Signed — 11/02/2018

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 disease/a disorder in which the immune system turns against the body's own tissues. In people with Hashimoto's, the immune system attacks the thyroid . This can lead to hypothyroidism, a condition in which the thyroid does not make enough hormones for the body's needs; Bilateral - both sides; BIMS - (Brief Interview for Mental Status) - assessment of the resident's mental status. The total possible BIMS Score ranges from 0 to 15; BiPAP - machine that helps the patient breathe; Calcium Acetate - medication used to prevent high blood phosphate levels in residents who are on dialysis; Calcium Carbonate - an insoluble salt occurring naturally in bone, used as an antacid, calcium supplement, and phosphate binder, and for treatment of osteoporosis; Cerebral Vascular Accident (CVA) - (Stroke) a condition involving reduced blood supply to the brain from intracerebral hemorrhage, thrombosis, embolism, or vascular insufficiency; Citalopram - a medicine for depression; cm - centimeter; CNA - Certified Nurse's Aide; Cognition - mental process; thinking; Cognitively Impaired - abnormal mental processes; thinking OR mental decline including losing the ability to understand, the ability to talk or write, resulting in the inability to live independently; Contracture - abnormal shortening of muscle tissue, rendering the muscle highly resistant to stretching; this can lead to permanent disability; Continence - control of bladder and bowel function; COPD- chronic obstructive pulmonary disease; a lung diseases that blocks airflow and makes it difficult to breathe;	F 000		

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F 000	Continued From page 2 Coumadin - brand name of Warfarin, an anticoagulant or blood thinner; CPAP - machine for breathing assistance during sleep; Dementia - a severe state of cognitive impairment characterized by memory loss, difficulty with abstract thinking, and disorientation OR loss of mental functions such as memory and reasoning that is severe enough to interfere with a person's daily functioning; Dialysis - cleansing of the blood by artificial means when kidneys have failed; Documentation survey report - electronic system where CNAs document the care provided for each resident; DON - Director of Nursing; eMAR - electronic Medication Administration Record; End Stage Renal Disease (ESRD) - disease where the kidneys stop working; Enoxaparin Sodium (Lovenox) - injectable medication used to prevent and treat harmful blood clots; helps reduce the risk of a stroke or heart attack; helps keep blood flowing smoothly by lowering the activity of clotting proteins in the blood; an anticoagulant, also known as a blood thinner; ER - Emergency Room; Escitalopram (Lexapro) - medication used to treat depression and certain types of anxiety; etc.-and so forth; eTAR - electronic Treatment Administration Record; Extensive Assistance - While the resident performed part of the activity over the last 7 day period, help of the following type was provided 3 or more times: weight bearing support; full staff performance during part (but not all) of the last 7 days; OR resident involved in activity, staff	F 000		

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F 000	Continued From page 3 provide weight-bearing support; Frequently Incontinent - 7 or more episodes of urinary incontinence, but at least one episode of continent voiding during a 7 day look back period Geri chair - wheelchair-type chair that reclines Hemiplegia - paralysis of one side of the body; Hypothyroidism -under active thyroid gland that includes symptoms such as fatigue, weight gain, muscle weakness, muscle aches, slowed heart rate, memory problems and depression; Hypoxia / Hypoxic - inadequate cellular oxygenation OR deficiency in amount of oxygen reaching body tissues; INR - International Normalized Ratio/a blood test performed via a blood draw from a vein or via a fingerstick that measures how long it takes blood to clot; Kardex - paper or electronic document that identifies resident specific care a CNA is to provide; LE - lower extremities; Levothyroxine Sodium (Synthroid) - an oral thyroid hormone medication used to treat hypothyroidism (under active thyroid gland); LPN - Licensed Practical Nurse; Malnutrition - lack of sufficient nutrients in the body; MCG (mcg)- micrograms; unit of weight; MDS - Minimum Data Set/standardized assessment tool used in long term care facilities; Mirtazapine - medication that is used to treat depression; ML (ml) - milliliter, unit of liquid; MG/mg-milligrams-unit of weight; MRR - Medication Regimen Review; NHA - Nursing Home Administrator; Offloading - removal of pressure from an area; Olanzapine - A medication used to treat schizophrenia, psychotic disorders, and bipolar	F 000		

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F 000	Continued From page 4 disorder. Bipolar disorder is also known as manic-depression; PASARR - Preadmission Screening and Resident Review/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; Passive Range of Motion - refers to someone physically moving a part of your body for you; this requires no effort on the part of the resident; Persistent vegetative state - a disorder of consciousness in which patients with severe brain damage are in a state of partial arousal rather than true awareness; PhosLo - medicine used to treat high levels of phosphate in patients with chronic renal failure; Pressure Ulcers (PUs) - sore area of skin that develops when the blood supply to it is cut off due to pressure; Pressure Ulcer Stage II (2) - skin blisters or skin forms an open sore. The area around the sore may be red and irritated; Pressure Ulcer Unstageable - tissue loss in which actual depth of the ulcer is unable to be determined due to the presence of slough (yellow, tan, gray, green or brown dead tissue) and/or eschar (dead tissue that is tan, brown or black and tissue damage more severe than slough in the wound bed); PRN - as needed; Psychosis - loss of contact/touch with reality; PT - Physical Therapist; Quadriplegia - paralysis of arms and legs; Quetiapine - is an antipsychotic medication that is used to treat schizophrenia and bipolar disorder, also known as manic-depression. It is	F 000		

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F 000	Continued From page 5 also used to treat major depression in combination with antidepressants; RN - Registered Nurse; RNAC - Registered Nurse Assessment Coordinator; ROM - how far you can move your joints in different directions; Sacrum/sacral - large triangular bone at base of spine; Sleep Apnea - sleep disorder characterized by abnormal pauses in breathing or instances of abnormally low breathing during sleep; Subcutaneously - a shot given into the fat layer between the skin and muscle; used to give small amounts and certain kinds of medicine; Sucralfate - a medication that helps to treat ulcers of the intestine; T4 - also known as thyroxine, which is a hormone produced by the thyroid gland and helps control metabolism and growth; Tizanidine - a medication that helps to relieve muscle spasms; Tracheostomy - a medical procedure, either temporary or permanent, that involves creating an opening in the neck in order to place a tube into a person ' s windpipe to assist with breathing; Tracheal suctioning-removal of secretions by a suction tube from the trachea; Trazodone - a medication used to treat depression; x-times; UE - upper extremities.	F 000		
F 550 SS=E	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	F 550		11/16/18

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F 550	Continued From page 6 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. §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 and interview, it was	F 550	The Statements made on this plan of	

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F 550	Continued From page 7 determined that for 3 (R24, R39, and R81) out of 47 sampled residents, the facility failed to 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 failed to treat residents with respect and dignity during lunch dining observations in the New Castle Unit on 9/20/18 and breakfast observations in the Arcadia Unit (locked dementia unit) on 9/21/18. Findings include: The following observations were made on 9/20/18 while trays were delivered to resident rooms in the New Castle unit: 1a- 12:19 PM: E6 and E7 (CNA) entered room 134 (R39 and R81); they knocked and entered the room without asking for permission to enter; b- 12:36 PM: E10 entered room 142 (R24), then knocked and entered the room without asking for permission to enter. The following observations were made on 9/20/18 in the New Castle dining room: 2.- 12:27 PM: E7 (CNA) asked E11 (LPN) if (name of resident- was unsure which resident was named) in the dining room was a "feeder" and E11 replied that the resident in question was a "feeder." There were other residents in the dining room at this time; approximately 6-7. 3.- 12:30 PM: E7 came up from behind R79 and placed a clothing protector around her neck without asking the resident if she wanted one. Findings were reviewed on 10/2/18 at 5:55 PM	F 550	correction are not an admission to and do not constitute an agreement with alleged deficiencies herein. To remain in compliance with all federal and state regulations, the facility has taken or will take the actions set forth in this plan of correction. The following plan of correction constitutes the facility□s allegation of compliance. All alleged deficiencies have been or will be corrected by the date or dates indicated. It is the intent of the facility to ensure a resident has the right to a dignified existence, self-determination, and communication with and access to personas and services inside and outside the facility, including those specified in this section. A. R24, R39, and R81 were affected by this practice. R16 was dressed appropriately at time observed naked. B. Current residents who reside in facility have the potential of being affected by this practice. Director of Nursing or Designee will conduct audit of hallways to determine if staff are entering room after knocking and receiving permission, are not referring to residents needing assistance with feeding as feeder at meal time, asking resident if they desire to wear a clothing protector in dining room, and resident is dressed appropriately and covered when in public view. C. The Staff Development Coordinator or	

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F 550	Continued From page 8 with E3 (ADON). 4. 8:20 AM: R50 was observed being transported to the Arcadia Unit dining room for breakfast in a geri chair by E4. R50's stomach area was uncovered, revealing 6 to 7 inches of the stomach including the resident's navel. Upon getting R50 situated at the table, E4 pulled down R50's top to cover the exposed stomach. 5. Observations of R16 revealed the following: On 9/20/18 in the Arcadia Unit, the following was observed: 3:32 PM- R16 was observed lying naked in room 104 in A bed, within view of anyone in the hallway; 3:33 PM- E5 (CNA) walked past room 104, glanced into the room and continued walking down the hallway; 3:42 PM- R16 was observed walking into the hallway naked, then going back into room 104 and going into the bathroom; 3:53 PM- E6 (CNA) observed that R16 was naked, went into room 104, shut the door and assisted R16 with getting dressed. On 9/20/18 at 4:00 PM, during an interview, E6 (CNA) stated that R16's bed is 104 B. E6 stated that R16 often undresses herself. E6 stated that R16 has gotten into 104 A bed previously, and also lies in other beds that are not her own. The facility failed to treat R16 with dignity and respect, when staff ignored the fact that she was sleeping naked on a bed within sight of anyone who walked by the room. Findings were reviewed with E2 (DON) and E3 (ADON) on 10/1/18 at 5:10 PM	F 550	designee will re-educate nursing staff to knock and wait for a response from resident prior to entering a room, not to refer to residents requiring assistance with feeding as feeder, to ask resident whether they desire to wear a clothing protector in dining room, and to ensure residents are dressed appropriately and covered when in public view. D. The director of Nursing or Designee will randomly audit hallways to ensure staff are knocking and waiting for a response prior to entering a resident room, randomly audit meals to ensure staff are not referring to residents who require assistance with feeding as feeders, to ensure staff are asking residents if they desire to wear a clothing protector in dining room, and to ensure residents are dressed appropriately and covered when in public view. Audits will be completed daily x 5 days, weekly x 2, and monthly x 2 to ensure substantial compliance. Results will be provided to the Quality Assessment and Assurance Committee for review and action as appropriate up until 100% compliance is met. The committee will determine need for further audits and/or action plans.	

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F 550	Continued From page 9 6. Observations of R95 revealed the following: On 9/26/18 at 11:25 AM, R95 was wheeled into the Cyber Cafe by E7 and placed at a table. There were no other occupants in the room at that time. At 11:30 AM, E7 returned to the Cyber Cafe, picked up a clothing protector and placed it on R95 without first asking permission to do so. At 11:37 AM, E7 delivered R95's meal to her, never speaking to R95 throughout this time. The facility failed to treat R95 with dignity and respect, when staff placed a clothing protector on her without asking first asking if she wanted it. Findings were reviewed with E2 (DON) and E3 (ADON) on 10/1/18 at 5:10 PM.	F 550		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interviews, it was determined that for one (R314) out of 47 sampled residents, the facility failed to provide services in the facility with reasonable accommodation of her needs and preferences. For R314, the facility failed to ensure that her call bell was within reach while she was sitting in her wheelchair in her room. Findings include: Review of R314's clinical record revealed:	F 558	It is the intent of the facility to provide the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. A. R314 was affected by this practice.	11/16/18

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F 558	Continued From page 10 9/17/18 - R314 was admitted to the facility for short-term rehabilitation after an amputation of 2 toes on her left foot. 9/21/18 at 9:37 AM - During an interview with the Surveyor, R314 was complaining of severe left foot pain. An observation by the Surveyor revealed that R314's call bell was wrapped up in her bed linens, which were placed on top of her bedside table and not within R314's reach. 9/21/18 at 9:45 AM - During an interview, E26 (CNA) stated that she was in the process of making R314's bed when she heard another resident yelling. E26 stated that she left R314's room to respond to the other resident. Finding was immediately confirmed with E26. 10/2/18 at 7:30 PM - Finding was reviewed with E1 (NHA) and E2 (DON) during the Exit Conference. The facility failed to ensure that R314 had her call bell within reach while she was sitting in her wheelchair in her room.	F 558	B. Current residents have the potential of being affected by this practice. Director of Nursing or designee will conduct audit of current residents to ensure call bells are within reach of resident. C. Staff Development Coordinator or designee will reeducate nursing staff to ensure call bell is within reach of resident. D. Director of nursing or designee will randomly audit resident call bells to ensure they are in reach of resident. Audits will be completed daily x 5 days, weekly x 2, and monthly x 2 to ensure substantial compliance. Results will be provided to the Quality Assessment and Assurance Committee for review and action as appropriate up until 100% compliance is met. The committee will determine need for further audits and/or action plans.	
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and	F 637		11/16/18

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F 637	Continued From page 11 requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that a significant change MDS assessment was not completed after a decline in status for one (R7) out of 47 sampled residents. Findings include: Review of R7's clinical record revealed: 3/14/18 - R7's Quarterly MDS Assessment documented that she was a 15 BIMS (cognitively intact), required limited assistance for toileting and was identified as being always continent of bowel. 6/14/18 - R7's Quarterly MDS Assessment showed a decline from her 3/14/18 MDS. It was identified that R7 was now an 8 BIMS (moderately impaired cognition), and required extensive assistance for toileting, and was identified as frequently incontinent of bowel. Review of R7's MDS assessments showed that a significant change MDS was not completed after R7's decline in status. During an interview with E21 (MDS Coordinator) on 9/26/18 at approximately 3:30 PM, it was confirmed that a significant change MDS was not completed for R7 after her decline. E21 stated that a significant change MDS would be started immediately. Findings were reviewed with E1 (NHA) and E2 (DON) on 10/1/18 at approximately 5:10 PM.	F 637	It is the intent of this facility to complete a significant change assessment within 14 days after the facility determines there has been a significant change in the residents physical or mental condition. A. R7 was affected by this practice. R7 significant change assessment was completed. B. Current residents have the potential of being affected by this practice. NHA or designee will conduct audit of current residents Quarterly MDS assessments to ensure sig change assessment was completed when a significant decline of two or more areas of resident physical or mental condition are noted. C. NHA or designee will reeducate RNACs on completing a Sig change assessment when a significant decline of two or more areas of resident physical or mental condition are noted. D. NHA or designee will audit current residents' Quarterly MDS to ensure sig change assessment was completed if required. Audits will be completed daily x 5 days, weekly x 2, and monthly x 2 to ensure substantial compliance. Results will be provided to the Quality Assessment and Assurance Committee for review and action as appropriate up until 100% compliance is met. The committee will	

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F 637	Continued From page 12	F 637	determine need for further audits and/or action plans.	
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section-	F 645		11/16/18

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F 645	Continued From page 13 (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview it was determined that the facility failed to ensure the completion of a PASARR for one (R66) out of 47 sampled residents. An exception for the completion of a PASARR included when an attending physician has certified, before	F 645	It is the intent of this facility to complete PASARR for those residents admitted to facility. A. R66 was affected by this practice. R66 PASARR was completed on 9/25 and	

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F 645	Continued From page 14 admission to the facility that the individual is likely to require less than 30 days of nursing facility services. Despite R66 exceeding the 30 day stay the facility failed to ensure that a PASARR was completed. Findings include: R66's clinical record revealed the following: 6/18/18 - A signed Physician's Exemption Certificate from PASARR stated that R66 had indicators of mental illness, mental retardation/related conditions but "Meets Physician's Exemption Criteria" for convalescence care and that this admission is not anticipated to exceed 30 days. 6/18/18 - R66 was admitted to the facility. 6/25/18 - The admission MDS assessment stated there was no PASARR completed. 6/26/18 - R66 was sent to the ER for evaluation and was subsequently admitted to the hospital. 6/29/18 - R66 was readmitted to the facility. 7/10/18 - R66 was sent to the ER for evaluation and was admitted to the hospital. 7/25/18 - R66 was readmitted to the facility. Later in the day, R66 was sent to the ER and was again admitted to the hospital. 8/14/18 - R66 was readmitted to the facility. 9/25/18 - Review of R66's clinical record revealed the absence of a PASARR. The facility failed to ensure that a PASARR was	F 645	determination received on 10/1/18. B. Current residents have the potential of being affected by this practice. NHA audited current resident PASARR assessments who admitted between 9/1/18 and 9/30/18 to determine if a Physician Exemption Certificate indicated "meets physician exception criteria" and the PASARR is completed timely. C. NHA or designee will reeducate Social services and Admissions to ensure each resident has a PASARR assessment upon admission, and the of requirement to complete PASARR prior to physician exemption expiration of 30days. D. NHA or Designee will audit new admissions to ensure PASSAR assessment is present at admission, and if Physician Exemption Certificate indicates "meets physician exception criteria" the PASARR is completed timely. Audits will be completed daily x 5 days, weekly x 2, and monthly x 2 to ensure substantial compliance. Results will be provided to the Quality Assessment and Assurance Committee for review and action as appropriate up until 100% compliance is met. The committee will determine need for further audits and/or action plans.	

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F 645	Continued From page 15 completed for R66 when the 30 day nursing facility stay was exceeded. 9/25/18 3:25 PM - During an interview with E1 (NHA) the absence of a PASARR was reviewed and confirmed. 10/1/18 - E1 provided the surveyor with a copy of the PASARR which had been completed on 10/1/18.	F 645		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §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	F 656		11/16/18

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F 656	Continued From page 16 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 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. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R67) out of 47 sampled residents, the facility failed to develop and implement a care plan to reflect R67's refusal for nail cutting. Findings include: Cross refer F677 Review of R67's clinical record revealed: R67 was admitted to the facility on 8/9/18. R67's admission MDS, dated 8/16/18, stated that R67 required extensive assistance with personal hygiene, which included nail trimming. R67 had a care plan, last reviewed on 8/10/18, for the problem that R67 had an ADL self-care deficit related to physical limitations. Interventions included to assist R16 with daily hygiene, grooming, dressing, oral care, and eating as needed. The care plan lacked specific interventions for nail care.	F 656	It is the intent of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with the residents rights set forth. A. R67 was affected by this practice. Resident was care planned for refusing nail cutting services. B. Current residents have the potential of being affected by this practice. Director of nursing or designee will audit current residents who have the preference to keep nails long to determine if refusal care plan is in place. C. Director of nursing or designee will reeducate nursing staff on documenting refusal of nail cutting service and ensuring a care plan for refusal of nail cutting is implemented.	

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F 656	Continued From page 17 R67 was observed on 9/20/18 at 2:53 PM, 9/21/18 at 10:43 AM, 9/24/18 at 2:51 PM, and 9/25/18 at 10:27 AM, with very long, dirty, and discolored finger nails. On 9/25/18 at 11:55 AM, E14 (CNA) stated that she offered to cut R67's nails for the past few days and she refused. E14 stated that she did not document that R67 was refusing to have her nails cut. Review of R67's care plan lacked evidence that she refused nail cutting. Findings were reviewed with E1 (NHA) and E2 (DON) on 10/1/18 at approximately 5:10 PM.	F 656	D. Director of nursing or designee will audit residents who have the preference to keep nails long to ensure refusal is documented in the care plan. Audits will be completed daily x 5 days, weekly x 2, and monthly x 2 to ensure substantial compliance. Results will be provided to the Quality Assessment and Assurance Committee for review and action as appropriate up until 100% compliance is met. The committee will determine need for further audits and/or action plans.	
F 658 SS=D	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 observation, review of the manufacturer's instructions for use, and interview, it was determined during the medication pass on 9/25/18 at 8:15 AM that E20 (LPN) failed to meet professional standards of quality when administering Spiriva Handihaler (medication used to treat breathing problems) to R38. Findings include: The manufacturer's (Boehringer Ingelheim-Pfizer) Patient's Instructions for Use for Spiriva	F 658	It is the intent of this facility to provide services that meet the professional standards of quality. A. R38 was affected by this practice. Employee was educated to instruct resident on the proper technique for Spiriva inhaler administration. B. Current residents have the potential to be affected by this practice. Director of	11/16/18

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F 658	Continued From page 18 Handihaler, last revised on 8/31/06, were reviewed. Spiriva is used to treat COPD. The capsule containing dry powder is opened with a piercing button which makes holes in the capsule and allows the medication to be released when breathed in (through a mouthpiece). The instructions stated, "... 5) Breathe out completely... 6)... Breathe in slowly and deeply but at a rate sufficient to hear or feel the capsule vibrate. Breathe in until your lungs are full; then hold your breath as long as is comfortable... To ensure you get the full dose of Spiriva, you must repeat steps 5 and 6 once again." Review of R38's clinical record and medications included, Spiriva handihaler 18 mcg 2 puffs inhale orally one time day. Review of R38's 7/20/18 quarterly MDS assessment, coded him as a 6 for cognition (severely impaired- never/rarely made decisions). On 9/25/18 at 8:15 AM during the medication pass, E20 (LPN) was observed administering R38's Spiriva Handihaler. E20 prepared the medication and handed it to R38. E20 failed to instruct R38 to breathe out completely before each inhalation (and R38 did not do it) and to hold each inhalation in as long as he was able to (R38 took in a quick breath for each inhalation and breathed back out right away). E20 was interviewed on 9/25/18 at 10:02 AM and findings were reviewed. E20 confirmed the findings. E3 (ADON) was interviewed on 10/2/18 at 5:55 PM and findings were reviewed.	F 658	nursing or designee will audit current residents with Spiriva Handihaler to ensure Care plans include providing education on use of inhaler prior to administration. C. Director of nursing or designee will reeducate licensed nurses on providing inhalation instruction to residents with Spiriva handihaler to ensure education is provided prior to administration. D. Director of Nursing or designee will audit residents on Spiriva Handihaler to ensure instruction is provided by the licensed nurse prior to administering. Audits will be completed daily x 5 days, weekly x 2, and monthly x 2 to ensure substantial compliance. Results will be provided to the Quality Assessment and Assurance Committee for review and action as appropriate up until 100% compliance is met. The committee will determine need for further audits and/or action plans.	

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F 677	Continued From page 19	F 677		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, it was determined that the facility failed to provide the necessary services to maintain good nail grooming for one (R67) resident, who was unable to carry out activities of daily living, out of 47 sampled residents. Findings include: Review of R67's clinical record revealed: R67 was admitted to the facility on 8/9/18. R67's admission MDS, dated 8/16/18, stated that R67 required extensive assistance with personal hygiene, which included nail trimming. R67 had a care plan, last reviewed on 8/10/18, for the problem that R67 had an ADL self-care deficit related to physical limitations. Interventions included to assist R16 with daily hygiene, grooming, dressing, oral care, and eating as needed. R67 was observed on 9/20/18 at 2:53 PM, 9/21/18 at 10:43 AM, 9/24/18 at 2:51 PM, and 9/25/18 at 10:27 AM, with very long, dirty, and discolored finger nails. During an interview on 9/25/18 at 11:44 AM, E13 (LPN Nurse Supervisor) stated that staff do not specifically document nail cutting that it was considered a standard of care under the personal	F 677	It is the intent of this facility to provide the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. A. R67 was affected by this practice. Resident refusal was care planned. B. Current residents have the potential of being affected by this practice. Director of nursing or designee will audit current residents who prefer to keep long nails to determine if refusal care plan is in place. C. Director of nursing or designee will reeducate licensed nursing staff ensuring a care plan for refusal of nail cutting is implemented. D. Director of nursing or designee will audit residents who prefer to keep long nails to ensure refusal is documented in the care plan. Audits will be completed daily x 5 days, weekly x 2, and monthly x 2 to ensure substantial compliance. Results will be provided to the Quality Assessment and Assurance Committee for review and action as appropriate up until 100% compliance is met. The committee will determine need for further	11/16/18

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F 677	Continued From page 20 hygiene task. On 9/25/18 at 11:55 AM, E14 (CNA) stated that she offered to cut R67's nails for the past few days and she refused. E14 stated that she did not document that R67 was refusing to have her nails cut. The facility failed to maintain good nail grooming services for R67 and failed to document any refusals for care. Findings were reviewed with E1 (NHA) and E2 (DON) on 10/1/18 at approximately 5:10 PM.	F 677	audits and/or action plans.	
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observations, record review and interviews, it was determined that the facility failed to provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choices of activities, designed to meet the interests of and support the physical, mental and psychosocial well-being of each	F 679	It is the intent of this facility to provide an ongoing program to support residents in their choice of activities designated to meet the interests of and support the physical, mental, and psychosocial wellbeing of each resident. A. Resident R37 was affected by this	11/16/18

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F 679	Continued From page 21 resident for one (R37) out of 47 sampled residents. Findings include: Review of R37's clinical record revealed the following: 1/10/18 - R37 was admitted to the facility with diagnoses that included persistent vegetative state, hemiplegia and tracheostomy. R37 required administration of oxygen and also required feedings via a tube inserted into the stomach. 1/10/18 - A care plan for "enjoys leisure groups in a sensory/passive manner such as pet visits, religious practices, socials/themed events and television/music programming. Resident may benefit from 1:1 (one to one) programming at bedside due to decreased group engagements/functions..." The care plan's goals were: "Resident will consider/accept encouragement to participate in group activities 1-2x (times) per week with focus of increased socialization (passive manner)...Resident will accept 1:1 visits at bedside of activities related to past and current interests 2 x week." Interventions included to assist to transport to and from activities of choice, encourage participation in group activities of interest, and provide adaptations of activities to accommodate participation in activities. 1/17/18 - The admission MDS assessment stated R37 was in a persistent vegetative state and was totally dependent on facility staff for all activities of daily living. 1/18/18 - A care plan stated "Desires to participate in outdoor hot/cold weather activities.	F 679	practice. Activities of interest and care plans have been reviewed and revised. B. Current resident have the potential of being affected by this practice. NHA or designee will audit current 1:1 residents to determine if 1:1 visits are completed per care plan, and participation logs are compete with documentation for the resident's activity of interest. C. NHA or designee will reeducated activity staff on documenting attendance to activity programs of interest on the participation log. Also, reeducation will be provided to activity staff on ensuring 1:1 visits are completed per care plan. D. NHA or designee will audit 1:1 residents to ensure 1:1 visits are completed per care plan and participation logs are complete with documentation of a resident's activity of interest. Audits will be completed daily x 5 days, weekly x 2, and monthly x 2 to ensure substantial compliance. Results will be provided to the Quality Assessment and Assurance Committee for review and action as appropriate up until 100% compliance is met. The committee will determine need for further audits and/or action plans.	

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F 679	Continued From page 22 At risk for complications...". Interventions included: avoid extended amount of time outdoors; observe for and report signs and symptoms of overexposure to heat and/or cold; offer and assist to apply sunscreen; and offer and assist to put on protective garb such as gloves, hat coat, etc., as needed. 1/18/18 - The facility's Recreation/Activity Evaluation stated that R37's lifetime occupation was bible counselor. It also stated R37's current interests included: pet visits; arts and crafts (sensory stimulation); cards/games (sensory stimulation); cooking baking (sensory stimulation); movies; music; outdoor activities; parties/socials; puzzles/word games; reading/writing; religious involvement; talking/conversing. Other interests listed included trivia, manicures, and sensory stimulation. The evaluation also stated R37 needed asistance with her wheelchair. Review of facility activity calendars and R37's participation logs revealed the following: July 2018: - Activity calendar stated pet visits occurred every Tuesday. R37's participation log stated she was "unavailable" on two days and there was no documentation on the other two days; - Activity calendar stated bible stories occurred every Wednesday, and on 7/7/18, 7/15/18, 7/18/18 and 7/21/18 there were other religious activities. The participation log documented that R37 was "Unavailable" on 7/7/18 and 7/15/18. There was no evidence that additional attempts were made to assist the resident to attend the other religious activities. - Review of R37's 1:1 activity logs revealed that only six visits were provided, instead of eight (2	F 679		

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F 679	Continued From page 23 per week as per the care plan). August 2018: - R37's participation log revealed that she was "unavailable" for four special and themed events; - There was no evidence that the facility attempted to assist R37 to any religious activities; - 1:1 activity logs revealed that only four of eight visits were provided. September 2018: - R37's participation log revealed she was "unavailable" for one religious activity. There was no evidence that the facility attempted to assist her to attend any others; - the participation log revealed that R37 was unavailable for one outdoor activity. There was no evidence that any other attempts were made; - participation log revealed that only one of four pet visits were provided; - 1:1 activity logs revealed that only four of eight visits were provided. The following observations were made of R37: 9/20/18 4:35 PM - lying in bed, tracks with eyes and turns head, tube feeding not currently in progress. 9/21/18 9:14 AM - lying in bed, tracking with eyes and turning head. Tube feeding is currently running. 9/24/18 11:02 AM - lying in bed, tracking with eyes and turning head. Tube feeding is currently running. 9/24/18 2:10 PM - dressed and seated in wheelchair in room next to bed. TV is playing and appears to be watching. Tube feeding is currently running. 9/25/18 10:40 AM - lying in bed asleep. Tube feeding was currently running. 9/25/18 12:07 PM - lying in bed awake. 9/27/18 3:00 PM - observed seated in w/c next to	F 679		

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F 679	Continued From page 24 bed, TV playing, appears to be engaged. The facility failed to provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choices of activities, designed to meet the interests of and support the physical, mental and psychosocial well-being for R37. 10/1/18 approximately 11:30 AM - During an interview with E25 (Activity Director) findings were reviewed. E25 stated, "we have to do better." 10/1/18 approximately 12:00 PM - Findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON). 10/2/18 approximately 2:40 PM - E1 stated that in July, 2018 the facility identified they had issues with activities, especially on their locked dementia unit. E1 stated their Corporate Consultant came out on 9/12/18 to review the facility's activity program and that they have not had time to address these concerns. E1 also stated that activity staffing numbers were down and there was no one to complete all the 1:1 visits with residents and that several times R37 had her tube feed running while the activities were occurring.	F 679		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with	F 686		11/16/18

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F 686	Continued From page 25 professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, interview, and review of other documentation as indicated, it was determined that for one (R110) out of 47 sampled residents, the facility failed to ensure that a resident with a pressure ulcer and at risk for pressure ulcers received the necessary treatment and services, consistent with professional standards of practice. For R110, a dependent resident admitted with a stage II sacral pressure ulcer that healed and reopened as an unstageable pressure ulcer, the facility lacked evidence that R110 was turned side to side to prevent skin breakdown. Findings include: National Pressure Ulcer Advisory Panel (NPUAP), Prevention and Treatment of Pressure Ulcers: Quick Reference Guide, second edition, published 2014, stated "Do not position an individual directly on a pressure ulcer...Continue to turn and reposition the individual regardless of the support surface in use." Review of R110's clinical record revealed: R110 was admitted to the facility on 8/10/18 with diagnoses that included generalized muscle weakness and malnutrition.	F 686	It is the intent of this facility to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable. A. R110 was affected by this practice. R110 has been discharged. B. Current residents have the potential of being affected by this practice. Director of nursing or designee will audit current residents with pressure ulcers to determine if repositioning is in place on the Kardex. C. Director of nursing or designee will re-educate nursing staff on ensuring repositioning is provided to resident who has a pressure ulcer. D.Director of nursing or designee will audit residents with pressure ulcers to ensure repositioning program is in place on Kardex. Audits will be completed daily x 5 days, weekly x 2, and monthly x 2 to ensure substantial compliance. Results will be provided to the Quality Assessment	

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F 686	Continued From page 26 Review of R110's progress notes revealed that on 8/10/18 at 8:30 PM, R110 was admitted to the facility from the hospital with a stage 2 sacral pressure ulcer. Review of R110's care plan revealed that starting on 8/10/18, R110 had a pressure ulcer to her sacrum related to incontinence, loss of mobility, bony prominence, and failure to change position frequently. There were no interventions documented to assist R110 with turning and repositioning. R110's admission MDS from 8/17/18, stated that R110 required extensive assistance for bed mobility. In addition, the MDS stated that R110 was at risk for pressure ulcers and had a current pressure ulcer, but was not on a turning and repositioning program. Review of R110's August, 2018 CNA documentation survey report revealed that there was no documented evidence that staff were turning and repositioning R110. R110's skin progress note, dated 8/20/18 at 7:55 AM, stated that the stage 2 sacral wound healed and R110 would continue on triad cream for protection of the skin. Review of R110's skin notes revealed that on 9/5/18 at 10:41 AM, R110's sacral wound reopened. The wound measured 4.8 by 2.5 by 0.2 cm and the wound bed was 75% yellow slough centrally. The resident currently had abnormal laboratory blood results and had poor nutritional intake. It was noted that R110 was dependent on staff for most care and to continue with offloading and prevention measures.	F 686	and Assurance Committee for review and action as appropriate up until 100% compliance is met. The committee will determine need for further audits and/or action plans.	

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F 686	Continued From page 27 R110's care plan was updated on 9/5/18, and stated that R110 had an open area to her sacrum related to impaired mobility, incontinence, and poor intake. Interventions included to encourage and assist R110 to turn and reposition. Review of R110's skin notes revealed that on 9/12/18 at 1:27 PM, R110's sacral pressure ulcer was now 4.8 by 1.9 by 0.2cm in size and the wound bed was unstageable with 90% slough. Review of R110's September, 2018 CNA documentation survey report revealed that there was no documented evidence that staff were turning and repositioning R110. During an interview on 9/25/18 at 11:00 AM, E27 (Wound Care Nurse) stated that there was not any documentation of staff turning and repositioning R110, but it was a standard of care. On 9/25/18 at 2:32 PM, F2 (R110's family member) stated she typically visits daily for at least 4 hours. F2 stated that R110 was not turned every 2 hours when she has been in the facility, and often she had to ask staff to turn R110 and fix her sacral wound dressing. The facility failed to ensure that R110, a dependent resident with a sacral pressure ulcer, was turned and repositioned to prevent skin breakdown. Findings were reviewed with E1 (NHA) and E2 (DON) on 10/1/18 at approximately 5:10 PM.	F 686		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3)	F 688		11/16/18

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F 688	Continued From page 28 §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, it was determined that the facility failed to provide services and/or treatment for one (R37) out of 47 sampled residents, who was at risk for a decrease in ROM. Findings include: The facility's nursing procedure, dated 1/2011, titled Range of Motion: Active/Passive, stated, "PURPOSE: To improve or maintain joint mobility and minimize potential of contractures...". R37's clinical record revealed the following: 1/10/18 - R37 was readmitted to the facility, post hospitalization, with diagnoses that included persistent vegetative state, hemiplegia and tracheostomy.	F 688	It is the intent of this facility to ensure a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable. A. R37 was affected by this practice. E19 was re-educated on reviewing plan of care. B. Current residents have the potential of being affected by this practice. Director of nursing or designee will audit current residents care plans to determine if passive range of motion is indicated in resident's plan of care.	

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F 688	Continued From page 29 1/10/18 - A care plan for "at risk for loss of range of motion," included the intervention "Passive ROM to bilateral UE/LE's (upper extremity/lower extremity) with care/ADLs." 1/17/18 - The admission MDS assessment stated R37 was in a persistent vegetative state and was totally dependent on facility staff for all ADLs. 7/23/18 - A care plan for "requires assistance/potential to restore function for mobility," included the intervention "provide passive range of motion exercises." Review of the CNA Kardex revealed that "provide passive range of motion exercises" and "passive ROM to bilateral UE/LE's with care/ADLs" were listed as part of R37's daily care needs. 9/26/18 11:25 AM - R37 was observed receiving morning care from E19 (CNA) with E17 (LPN) assisting. There were no passive ROM exercises performed during this observation of care as per the resident's care plan. 9/26/18 12:15 PM - During an interview, E17 confirmed that passive ROM exercises were not performed during AM care. 9/27/18 approximately 8:45 AM - During an interview, E19 confirmed that she had not performed passive ROM exercises the day before during the surveyor's observation of morning care. The facility failed to provide services and/or treatment for a resident at risk for a decrease in range of motion.	F 688	C. Director of nursing or designee will reeducate nursing staff on viewing resident's plan of care to determine if passive range of motion needs to be provided to resident. D. Director of nursing or designee will audit residents requiring passive range of motion to ensure nursing staff is performing as designated. Audits will be completed daily x 5 days, weekly x 2, and monthly x 2 to ensure substantial compliance. Results will be provided to the Quality Assessment and Assurance Committee for review and action as appropriate up until 100% compliance is met. The committee will determine need for further audits and/or action plans.	

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F 688	Continued From page 30 10/1/18 approximately 12:00 PM - Findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON).	F 688		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, clinical record review, and interview, it was determined that for three (R15, R16, and R23) out of 47 sampled residents, the facility failed to provide adequate supervision in the Arcadia unit (locked dementia unit) to prevent accidents. Findings include: 1. Review of R15's clinical record revealed: R15 was admitted to the facility on 9/14/16 with diagnoses that included dementia and CVA. A progress note dated 11/29/17 at 2:25 PM stated that, R15 had a fall that was witnessed by a visitor. R15 had wandered into room 117, which was not her room. The occupant of that room grabbed R15's hands to try to pull her out of the room, and R15 fell. R15 had a care plan that was last revised on 11/30/17 that stated; R15 was at risk for and had falls due to cognitive impairment, unsteady gait,	F 689	It is the intent of this facility to ensure each resident receives adequate supervision and assistance devices to prevent accidents. A. R15, R16, and R23 were affected by this practice. B. Current residents have the potential of being affected by this practice. Director of nursing or designee will conduct initial audit of Arcadia residents who independently ambulate to identify residents who may wander into wrong rooms. C.Director of nursing or designee will re-educate nursing staff that when in hallway, patients should be monitored to ensure residents are not wandering into the wrong room.	11/16/18

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F 689	Continued From page 31 poor safety awareness, impaired balance, and poor coordination. Interventions included redirecting R15 when she wandered into other resident's rooms. Review of the facility's investigation report, signed on 1/10/18, revealed, "A visitor approached staff to report patient had wandered into another resident's room, resident attempted to remove patient from room and patient fell ...Root cause analysis concludes that fall was related to patient's poor safety awareness related to dementia ...Patient will be redirected by staff when wandering, especially near other resident's rooms." Review of R15's record revealed that her room was 112A on the Arcadia unit. On 9/20/18 at 11:28 AM, R15 was observed wandering into room 104 and sitting on bed A. There were no staff in the hall supervising R15. On 9/21/18 at 9:32 AM, R15 was again observed wandering into room 104 and sitting on bed A. There were no staff in the hall supervising R15. On 9/21/18 at 9:39 AM, R15 wandered into room 105 and was shaking R23's lower leg to try and wake her up. There were no staff supervising R15 at that time. On 9/24/18 at 2:57 PM, R15 was observed sleeping in room 111 in bed A. E6 (CNA) and E12 (RN) were both aware that R15 was sleeping in another resident's bed and did not intervene or provide any supervision. During an interview on 9/24/18 at 3:21 PM, F1	F 689	D. Director of nursing or designee will audit Arcadia hallway to ensure residents are not wandering into the wrong rooms and redirected if so. Audits will be completed daily x 5 days, weekly x 2, and monthly x 2 to ensure substantial compliance. Results will be provided to the Quality Assessment and Assurance Committee for review and action as appropriate up until 100% compliance is met. The committee will determine need for further audits and/or action plans.	

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F 689	Continued From page 32 (R45's wife) stated that R15 was always in and out of other resident's beds on the Arcadia unit. She stated that on the Arcadia unit, many of the residents lay in other resident's beds and that it happened all the time. On 9/25/18 at 10:05 AM, R15 was observed leaving the activity room and wandering up and down the hall. No staff talked or redirected R15, and at 10:14 AM R15 was observed going into room 121 and sitting down on bed A. At 10:16 AM, R15 was observed wandering the hall again and was observed touching items on top of a medication cart outside of the activity room. E16 (PT) was in the hallway and did not redirect the resident. There were no other staff supervising R15 while she was wandering in the hallway. On 9/25/18 at 10:21 AM, R15 was observed going into room 107 and picking up a used glove out of the trash near A bed. R15 then left the room with the dirty glove in her hand and walked past E14 (CNA) and E15 (CNA). The staff members did not redirect or pay attention to the dirty glove in R15's hand. R15 then threw the dirty glove away in a medication cart and walked into the activity room. On 9/25/18 at 11:39 AM, R15 was observed laying in room 106 A bed and there was no staff supervision or redirection observed. The facility failed to provide adequate supervision to prevent R15 from wandering into other resident's rooms in order to prevent accidents. Findings were reviewed with E1 (NHA) and E2 (DON) on 10/1/18 at approximately 5:10 PM.	F 689		

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F 689	Continued From page 33 2. Review of R16's clinical record revealed: R16 was admitted to the facility on 6/5/18 with diagnoses that included dementia with behavioral disturbances. Review of R16's care plan, dated 6/5/18, for wandering/pacing related to cognitive impairment included interventions to allow to wander in hallway on Arcadia unit, redirect prn, attempt to minimize excess stimulation, encourage brief rest periods by sitting with resident and encouraging her to drink some fluids, and provide assistance in locating own room. A progress note, dated 6/19/18, stated R16 was observed taking a narcotics count book and walking around hiding it under her clothing. Book was taken from resident, and R16 was directed to dining room and offered activity books. A progress note, dated 6/21/18, stated that R16 removes under/outer garments frequently. Resident consistently ambulating in hallway naked. Multiple attempts to educate resident about the possible safety issues that could occur. Remains non-compliant. Toileted frequently. A progress note, dated 6/29/18, stated that R16 had multiple episodes of disrobing and ambulating in hallway (10). Assisted back to room and explained she (resident) has to have clothing on when ambulating in hallway. A progress note, dated 7/6/18, stated that R16 continues to disrobe and becomes very aggressive when attempting to redirect. Ambulating room to room and sitting on others beds unclothed. Assisted back to room, but	F 689		

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F 689	Continued From page 34 becomes angrier. Review of R16's care plan, dated 7/17/18, for inappropriate undressing removes clothing related to cognitive impairment and other diagnoses. Removes non-skid shoes despite staff re-applying throughout shift- assist to remove extra clothing and put away, attempt to re-apply footwear as resident allows, elicit family input for best approaches, if resident has body types exposed, attempt to dress resident. If refuses, notify nurse and try again after resident calms down, notify family and make arrangements to obtain adaptive clothing if needed. A progress note, dated 9/7/18, stated that R16 was noted on the floor in another residents room at 3:20 (does not specify AM or PM), she was lying on the left side, no hazards noted, she had a 2cm x 2cm skin tear on her right knee, she was dry at that time, nurse assessed resident no signs/symptoms of pain. R16 had a care plan for being at risk for falls/actual falls, last revised on 9/10/18. Interventions included to provide assistance to transfer and ambulate as needed, provide assistance with non-skid socks, to be placed on both feet prior to bed, and provide safe environment to sleep on floor when places self on floor, such as pillows, redirect to safe place such as bed if on floor in unsafe area such as doorway. Review of a quarterly MDS assessment, dated 9/12/18, coded R16 with a BIMS of 3 (severe cognitive impairment- never/rarely made decisions) and she had wandering behavior 1-3 days out of 7.	F 689		

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F 689	Continued From page 35 On 9/20/18 at 3:33 PM, R16 was observed by another surveyor laying in her roommates bed naked. The other surveyor spoke to E6 (CNA) on 9/20/18 at 3:53 PM who stated that the resident does this all the time, she takes off her clothes and lays in other residents beds and on chairs. E6 came to the room where R16 was laying naked when she saw 2 surveyors observing the resident; R16 had already been laying in the bed naked for 20 minutes when E6 observed her. On 9/21/18 at 9:44 AM , R16 was observed walking into and then back out of room 114 (this was not her room). R16 had non-skid socks, slacks and blouse that was partially untucked. On 9/21/18 at 9:46 AM, R16 was observed walking into room 111 (not her room) and the resident sat on the side of the bed. On 9/26/18 at 12:24 PM, R16 got up out of her bed; she appeared to have just awakened from a nap. She got up and walked into room 103 (not her room), pulled her pants down and sat on B bed. Staff saw R16 and took her to the bathroom in room 103. The facility failed to provide adequate supervision to prevent R16 from wandering into other resident's rooms in order to prevent accidents. Findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) during the exit conference on 10/2/18 at approximately 7:15 PM. 3. Review of R23's clinical record revealed: R23 was admitted to the facility to room 105B on the Arcadia unit on 6/22/17 with diagnoses that	F 689		

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F 689	Continued From page 36 included dementia with behaviors. A care plan initiated on 7/31/17, revealed that R23 was exit seeking, an elopement risk, wandered on the unit, and tried to open doors related to cognitive impairment. Interventions included to encourage socialization, redirect, encourage rest, and provide supervision. On 9/20/18 at 8:55 AM, R23 was observed walking out of the Arcadia dining room and going through the trash on the medication cart. R23 was redirected by a surveyor and then went to the exit door and tried to open the door multiple times. R23 then walked into room 110 where the occupant of that room became irritated and began yelling. R23 left that room and went into the hallway. There were no staff in the hall providing supervision for R23. On 9/20/18 at 3:26 PM, it was observed that a peach blouse that R23 had been wearing earlier in the day was lying on B bed in room 113. On 9/25/18 at 11:40 AM, R23 was observed wandering into room 108 and then attempted to push open the closed door of room 106. There were no staff in the hall providing supervision for R23. On 9/26/18 at 3:48 PM, R23 was observed sleeping in bed 111A. Staff were not attempting to intervene or provide supervision for R23. The facility failed to provide adequate supervision to prevent R23 from wandering into other resident's rooms in order to prevent accidents. Findings were reviewed with E1 (NHA) and E2	F 689		

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F 689	Continued From page 37	F 689		
	(DON) on 10/1/18 at approximately 5:10 PM.			
F 695 SS=E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)	F 695		11/16/18
	§ 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and review of facility nursing procedures it was determined that the facility failed to ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for 2 (R37 and R57) out of 47 sampled residents. For R37, the facility failed to ensure that sterile procedures were maintained during tracheostomy care and tracheal suctioning. For R57, the facility failed to follow their policy by not documenting CPAP care and they failed to provide necessary respiratory care consistent with professional standards of practice by not cleaning R57's CPAP machine on multiple occasions. Findings include: 1. The facility's nursing procedure, titled "Gloves: Non-Sterile/Sterile, dated 12/2009, stated, "...STERILE: 1. Perform hand hygiene 2. Open latex free sterile glove package touching only		It is the intent of this facility to ensure a resident who needs respiratory care is provided such care, consistent with professional standards of practice. A. R37 and R57 were affected by this practice. E17 was provided education. R57 CPAP mask was cleaned on 10/1/18. B. Current residents have the potential of being affected by this practice. Director of nursing or designee will audit current residents to identify those with tracheostomies who need use of sterile glove procedure for tracheostomy suctioning. Director of nursing or designee will audit current residents with CPAP orders to ensure machine is cleaned per policy. C. Director of nursing or designee will re-educate licensed nursing staff on sterile glove procedure and appropriate	

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F 695	Continued From page 38 outside of package 3. With dominant hand, grasp opposite glove at inner edge of folded cuff, carefully slip hand into glove taking care not to touch remainder of glove...4. While still grasping inner edge of folded cuff, pull glove over free hand 5. With sterile gloved hand slip fingers into folded cuff of second glove 6. carefully slip glove over fingers and pull glove over hand, taking care not to touch skin with gloved hand 7. Both hands are now sterile; do not touch non-sterile surfaces...". The facility's nursing procedure, titled "Respiratory: Suctioning...Tracheostomy," stated, "...PREPARATION OF SUCTION EQUIPMENT: 1. Place suction equipment within reach 2. Position trash bag to receive disposable items 3. Attach tubing to suction unit...TRACHEOSTOMY INSERTION: 1. Using sterile technique, open sterile suction kit...2. Put on sterile latex free gloves - designate non-dominant hand, usually left hand as contaminated for disconnection and working suction control. Typically the dominant hand, usually right hand, is kept sterile and will be used to thread suction catheter. 3. Remove sterile catheter from package curling the catheter around gloved fingers and attach sterile suction catheter to tubing...SUCTIONING: 1. Apply intermittent suction by covering catheter suction valve with thumb...8. Clear connecting tubing by applying suction and aspirating remaining distilled water or sterile normal saline through it 9. Turn off suction machine and disconnect catheter from tubing 10. Discard catheter...". Observations revealed: Observation of E17 (LPN) providing tracheostomy care and tracheal suctioning for R37 on 9/26/18 at 11:10 AM revealed the following:	F 695	handling of suction catheter to reduce risk of contamination. Director of nursing or designee will re-educate nursing staff on procedure of CPAP cleaning per policy. d. Director of nursing or designee will audit tracheostomy care to ensure gloves and suction catheter do not become contaminated. Director of nursing or designee will audit CPAPs to ensure machine is cleaned per policy. Audits will be completed daily x 5 days, weekly x 2, and monthly x 2 to ensure substantial compliance. Results will be provided to the Quality Assessment and Assurance Committee for review and action as appropriate up until 100% compliance is met. The committee will determine need for further audits and/or action plans.	

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F 695	Continued From page 39 - E17 donned sterile gloves and while opening a sterile field dropped the packaging on the floor. E17 picked the packaging up off the floor with her gloved hand, thereby contaminating her sterile glove. After discarding the packaging into the trash, E17 did not remove the contaminated gloves. E17 then placed the top of her left gloved hand against the back of her hip further contaminating the gloved hand; - E17 removed a suction catheter and placed it on the sterile field. While connecting the suction catheter to the suction machine tubing, E17 did not curl the catheter around her gloved fingers to maintain sterility. Instead the tip of the catheter was moving around and touched the top of the suction machine causing the suction catheter to become contaminated. After suctioning R37, E17 placed the used suction catheter on top of the suction machine; - After suctioning R37, E17 removed the gloves, and used hand sanitizer. E17 applied new sterile gloves but had difficulty and touched the outside of the sterile glove with her other bare hand, contaminating the gloves. E17 again placed the top of her left gloved hand against the back of her hip, further contaminating the gloved hand. E17 proceeded to suction R37, reusing the contaminated catheter that had been placed on top of the suction machine; 9/26/18 approximately 12:15 PM - During an interview with E17 findings regarding contamination of sterile gloves and the reuse of a contaminated suction catheter were reviewed. The facility failed to ensure that sterile procedures were maintained during tracheostomy care and tracheal suctioning.	F 695		

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F 695	Continued From page 40 10/1/18 approximately 12:00 PM - Findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON). 2. Review of R57's clinical record, and interviews revealed: R57 was admitted to the facility on 8/3/16 with diagnoses of quadriplegia, contracture of the right hand, chronic pain, depressive disorder, and sleep apnea. Review of R57's orders showed a physician's order dated 7/26/17, for R57 to have CPAP at hs (hour of sleep). An annual MDS dated 8/12/18 revealed R57 had a BIMS of 15 - cognitively intact. On 9/21/18 at 8:39 AM, during an interview, R57 stated he had a CPAP machine, but he was afraid to use it because it didn't get cleaned. R57 also stated he could die from not wearing the CPAP mask. On 10/1/18 at 1:40 PM, during an interview, E2 (DON) stated the facility didn't have any documentation regarding R57's CPAP cleaning. E2 stated cleaning the CPAP machine was part of the facility BiPAP/CPAP policy. When questioned by the surveyor as to how the facility would ensure CPAP cleaning was being done, E2 replied that administrative nursing staff (DON, ADON) would notice if cleaning wasn't being done because the machine would be dirty. On 10/1/18 at 2:02 PM, during an interview, R57 stated he had spoken with various nurses on his floor about cleaning his CPAP machine, most	F 695		

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F 695	Continued From page 41 recently within the past month, and he was told they didn't have time to clean it. R57 stated that when he was discharged from the hospital to the facility he was instructed that the machine needed to be cleaned weekly. R57 stated because of his quadriplegia he was unable to clean the machine himself. R57 stated that his CPAP machine was cleaned a few days ago by E8. R57 stated that prior to that cleaning he had only worn his CPAP mask one time a week because he was worried about getting sick. On 10/1/18 at 4:13 PM, during an interview, E9 (RN) stated that all respiratory maintenance, was done on Saturday 11-7 shift. E9 stated there was no facility list of who had respiratory needs. E9 confirmed that if there were new or unfamiliar staff working on Saturday during the 11-7 shift, they would not know what to do in relation to respiratory maintenance. Review of the facility policy titled BiPAP/CPAP, original date 12/2009 and updated 7/2017, stated "suggested documentation: care provided in progress note...". The facility failed to follow their own policy by not documenting R57's CPAP care and by not providing necessary respiratory care consistent with professional standards of practice as evidenced by failure to clean R57's CPAP machine on a regular basis. Findings were reviewed with E1 (NHA), E2, and E3 (ADON) on 10/1/18 at 5:10 PM.	F 695		
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5)	F 756		11/16/18

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F 756	Continued From page 42 §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. §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:	F 756		

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F 756	Continued From page 43 Based on record review and interview, it was determined that the facility failed to act on and consistently sign and date irregularities identified during the pharmacist's medication regimen review (MRR) for 5 (R5, R23, R59, R95 and R113) out of 47 residents sampled. In addition, for one (R15) out of 47 sampled residents, the facility's pharmacist failed to identify a medication irregularity during the monthly medication regimen review. Findings include: The Synthroid website's Full Prescribing Information, dated 2018, stated, "Drugs That May Decrease T4 Absorption (hypothyroidism). Potential impact: Concurrent use may reduce the efficacy of Synthroid by binding and delaying or preventing absorption, potentially resulting in hypothyroidism ...Calcium Carbonate may form an insoluble chelate with levothyroxine ...Administer Synthroid at least 4 hours apart from these agents." 1. Cross refer F757 Review of R15's clinical record revealed: R15 was admitted to the facility on 9/14/16 with diagnoses that included hypothyroidism. On 9/14/16, R15 had a physician's order for Calcium Carbonate 600 MG tablet give 1 tablet by mouth two times a day as a supplement. This order was entered to be administered at 8:00 AM and 4:00 PM. On 9/14/16, R15 had a physician's order for Levothyroxine Sodium 100 mcg tablet give 1 tablet by mouth in the morning for hypothyroidism. This order was entered to be	F 756	It is the intent of this facility to have the drug regime of each resident reviewed at least month by a licensed pharmacist. A. R5, R15, R23, R59, R95 and R113 were affected by this practice. R15 orders for Levothyroxine Sodium and Calcium Carbonate have been changed to be administered at least 4 hours apart. Related to R5, R59, and R23, Education was provided to MD to respond, sign, and date the pharmacy recommendations. R95 dx has been updated. R113 Calcium Acetate order was change to be administered with meals. B. Current residents have the potential of being affected by this practice. Director of nursing or designee will audit Pharmacy recommendations in the last 30 days to ensure recommendations are responded to, signed, dated by physician and implemented if approved. C. Director of nursing or designee will reeducate pharmacist consultant on identifying and recommending a change when Levothyroxine Sodium and Calcium Carbonate are administered within 4 hour of each another. Director of nursing or designee will reeducate Attending Physician to respond, sign, and date pharmacy recommendations, and licensed nurses to implement recommendation if approved. D. Director of nursing or designee will audit Pharmacy recommendations to ensure recommendations are responded	

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F 756	Continued From page 44 administered at 6:00 AM. Review of R15's eMAR's from March 2018 through September 2018 revealed that R15 received Levothyroxine Sodium at 6:00 AM and Calcium Carbonate at 8:00 AM. An MRR was completed by the consultant pharmacist for R15 from March 2018 through September 2018 with no identified irregularities. The pharmacist failed to recognize during R15's MRR's from March 2018 through September 2018 the error of the facility administering R15's Levothyroxine Sodium and Calcium carbonate less than 4 hours apart. Findings were reviewed with E1 (NHA) and E2 (DON) on 10/1/18 at approximately 5:10 PM. 2. Review of R59's clinical record revealed: MRR's were completed by the consultant pharmacist for R59 from October 2017 to September 2018 with identified irregularities on 1/27/18, 2/21/18, 3/30/18, 6/30/18, and 7/28/18. The 1/27/18 pharmacist recommendation stated that R59 received Citalopram 20 mg daily for depression and an annual dose reduction evaluation was requested. It was recommended that the risks and benefits of continued use of Citalopram at current dose be documented and to consider a trial dose reduction from 20 mg daily to 10 mg daily. The physician never signed or responded to this recommendation. This medication was not reduced until it was discontinued on 4/19/18.	F 756	to, signed, dated by physician and implemented if approved. Audits will be completed daily x 5 days, weekly x 2, and monthly x 2 to ensure substantial compliance. Results will be provided to the Quality Assessment and Assurance Committee for review and action as appropriate up until 100% compliance is met. The committee will determine need for further audits and/or action plans.	

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F 756	Continued From page 45 The 2/21/18 pharmacist recommendation stated that R59 received Tizanidine HCl 6 mg 1 capsule every 6 hours for muscle spasms. It was recommended to evaluate for a possible dose reduction of this medication to 6 mg every 8 hours. The physician never signed or responded to this recommendation. The medication dose was not reduced until 5/2/18. The 3/30/18 pharmacist recommendation stated that R59 received Tylenol 325 mg tablets 2 tablets every 8 hours for pain and was also ordered Tylenol PRN. The recommendation was to discontinue R59's PRN Tylenol order. The physician declined the recommendation, but did not date the signature. The 6/30/18 pharmacist recommendation stated that R59 received Quetiapine Fumarate 50 MG tablet 1 tablet by mouth at bed time for recurrent depressive disorders. The pharmacist recommended to add a supportive reason for use or to consider tapering the medication with the goal of discontinuation. The physician declined due to the resident being followed by psychiatry, but did not date the signature. The 7/28/18 pharmacist recommendation stated that R59 received Escitalopram Oxalate 20 mg tablet 1 tablet daily for recurrent depressive disorders and received Mirtazapine 45 MG tablet 1 table at bedtime for recurrent depressive disorders. The pharmacist recommended that these medications may be considered duplicate therapy and to periodically reevaluate the risks and benefits of continued use of dual antidepressant therapy and to consider a trial dose reduction. The physician declined due to the resident being followed by psychiatry, but did not	F 756		

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F 756	Continued From page 46 date the signature. The facility failed to consistently act on and sign and date R59's monthly MRR pharmacy recommendations. Findings were reviewed with E1 (NHA) and E2 (DON) on 10/1/18 at approximately 5:10 PM. 3. Review of R5's clinical record revealed: MRR's were completed by the consultant pharmacist for R5 from October 2017 to September 2018 with an identified irregularity on 8/6/18. The 8/6/18 pharmacist recommendation stated that R5 received Sucralfate 1 GM tablet 1 tablet three times a day for gastritis (stomach irritation) 1 hour before meals and that Sucalfate had multiple drug interactions. The pharmacist recommended to reevaluate the risks and benefits of continued use of Sucralfate for this resident. The physician never signed or responded to this recommendation. The facility failed to ensure the signing and dating of R5's monthly MRR pharmacy recommendations. Findings were reviewed with E1 (NHA) and E2 (DON) on 10/1/18 at approximately 5:10 PM. 4. Review of R23's clinical record revealed: R23 was admitted to the facility on 6/22/17 with diagnoses that included dementia with behaviors. MRR's were completed by the consultant	F 756		

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F 756	Continued From page 47 pharmacist for R23 from October 2017 to September 2018 with identified irregularities on 1/21/18 and 5/16/18. The 1/21/18 pharmacist recommendation stated that R23 received Quetiapine 25 mg three times a day for dementia with agitation. The pharmacist recommended a trial dose reduction of Quetiapine 25 mg to two times a day for dementia with agitation. On 2/3/18, the physician accepted the recommendation to be implemented as written. Review of the eMARs from February, 2018 through April, 2018 revealed that this recommendation was not implemented until 4/4/18, two months later. The 5/16/18 pharmacist recommendation stated that R23 was ordered Lexapro Tablet 10 mg one time a day for depression. R23 was also receiving Trazadone 75 mg total daily dose for depression/anxiety. The pharmacist stated use of both medications may be considered duplicate therapy. The consultant pharmacist recommended reduction of Trazodone to 25 mg twice a day. The facility was unable to produce any documentation that the physician had accepted or declined the pharmacist's 5/16/18 recommendation. Findings were reviewed with E1 (NHA), E2 (DON), and E3 (ADON) on 10/1/18 at 5:10 PM. 5. Review of R95's clinical record revealed: An MRR was completed by the consultant	F 756		

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F 756	Continued From page 48 pharmacist for R95 on 9/12/18, with identified irregularities. The 9/12/18 recommendation stated that R95 received Olanzapine 5 mg 1 tablet at bedtime for unspecified psychosis. The recommendation was: clarify diagnosis for use; identify target behaviors nursing should be monitoring for; and periodically re-evaluate the risk versus benefits of antipsychotic medication in an older patient. On 9/14/18 the physician accepted the recommendation to be implemented as written. Review of R95's clinical record revealed no evidence of target behaviors that nursing should be monitoring for. The facility failed to implement the MRR recommendation to identify target behaviors for Olanzapine use for R95. Findings were reviewed with E1, E2, and E3 on 10/1/18 at 5:10 PM. 6. Review of R113's clinical record revealed the following: 9/6/18 - R113 was admitted to the facility for short-term rehabilitation with diagnoses of End Stage Renal Disease and dependent on dialysis. R113 was scheduled for dialysis outside of the facility on Monday, Wednesday and Friday. 9/12/18 - A MRR, conducted by the facility's pharmacist, identified an irregularity and recommended that R113's Calcium Acetate medication should be given "with meals". The	F 756		

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F 756	Continued From page 49 facility's physician accepted and signed the pharmacist's recommendation on 9/14/18. 9/14/18 through 9/24/18 - Review of R113's September 2018 eMAR revealed two Calcium Acetate medication orders: - Calcium Acetate - Give 1 capsule by mouth two times a day every Mon, Wed, Fri and timed for 7:30 AM and 4:30 PM; and - Calcium Acetate - Give 2 capsules by mouth before meals every Sun, Tue, Thu, Sat and timed 7:30 AM, 12 Noon and 4:30 PM. The two medication orders failed to specify the correct time of administration, "with meals". 9/27/18 at 5:35 PM - Findings were reviewed with E2 (DON) and E3 (ADON). The facility failed to ensure that R113's 9/12/18 MRR irregularity, which was accepted and signed by the physician, was carried out with respect to the timing of his Calcium Acetate medication administration, "with meals". 10/2/18 at 7:30 PM - Findings were reviewed with E1 (NHA) and E2 (DON) during the Exit Conference.	F 756		
F 757 SS=E	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or	F 757		11/16/18

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F 757	Continued From page 50 §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, interview, and review of manufacturer's instructions, it was determined that for one (R15) out of 47 sampled residents, the facility failed to ensure that the residents were free from unnecessary medications. For R15, the facility failed to have the correct amount of time per manufacturer's instructions between the administration of R15's Levothyroxine Sodium (Synthroid) and Calcium Carbonate. Findings include: The Synthroid website Full Prescribing Information, dated 2018, stated, "Drugs That May Decrease T4 Absorption (hypothyroidism). Potential impact: Concurrent use may reduce the efficacy of Synthroid by binding and delaying or preventing absorption, potentially resulting in hypothyroidism ...Calcium Carbonate may form an insoluble chelate with levothyroxine ...Administer Synthroid at least 4 hours apart from these agents." Review of R15's clinical record revealed:	F 757	It is the intent of this facility to for each resident drug regime to be free from unnecessary drugs. A. R15 was affected by this practice. R15 orders for Levothyroxine Sodium and Calcium Carbonate have been changed to be administered at least 4 hours apart. B. Current residents have the potential of being affected by this practice. Director of nursing or designee will audit current residents with orders for Levothyroxine Sodium and Calcium Carbonate to ensure administration is at least 4 hours apart. C. Director of nursing or designee will re-educate licensed nurses on identifying and recommending a change to the physician when Levothyroxine Sodium and Calcium Carbonate are scheduled within 4 hour of each another. D. Director of nursing or designee will	

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F 757	Continued From page 51 R15 was admitted to the facility on 9/14/16 with diagnoses that included autoimmune thyroiditis. On 9/14/16, R15 had a physician's order for Calcium Carbonate 600 MG tablet give 1 tablet by mouth two times a day as a supplement. This order was entered to be administered at 8:00 AM and 4:00 PM. On 9/14/16, R15 had a physician's order for Levothyroxine Sodium 100 mcg tablet give 1 tablet by mouth in the morning for hypothyroidism. This order was entered to be administered at 6:00 AM. Review of R15's eMAR's from March 2018 through September 2018 revealed that R15 received Levothyroxine Sodium at 6:00 AM and Calcium Carbonate at 8:00 AM. The facility failed to have R15's Levothyroxine Sodium and Calcium Carbonate administered at least 4 hours apart per manufacturer's instructions. Findings were reviewed with E1 (NHA) and E2 (DON) on 10/1/18 at approximately 5:10 PM.	F 757	audit residents to ensure orders for Levothyroxine Sodium and Calcium Carbonate are administered at least 4 hours apart. Audits will be completed daily x 5 days, weekly x 2, and monthly x 2 to ensure substantial compliance. Results will be provided to the Quality Assessment and Assurance Committee for review and action as appropriate up until 100% compliance is met. The committee will determine need for further audits and/or action plans.	
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on closed record review and interview, it was determined that the facility failed to ensure that one (R114) out of 47 sampled residents was	F 760	It is the intent of the facility for residents to be free of any significant medication errors.	11/16/18

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F 760	Continued From page 52 free of any significant medication errors. Findings include: R114's closed clinical record revealed the following: 6/22/18 - R114 was admitted to the facility, after a hospitalization, with diagnoses that included stroke and an irregular heart rhythm. 6/22/18 - The hospital Interagency Discharge Orders included the following: - check INR daily; - if INR < (less than) 2.0, give Lovenox therapeutic dose daily. 6/22/18 - The facility's physician orders included: - INR in AM on 6/22/18; this order was later discontinued on 6/22/18; - INR every Monday and Thursday; - Enoxaparin Sodium (Lovenox) solution 120 MG/0.8ML inject 115 mg subcutaneously as needed for INR < 2.0; - Warfarin (Coumadin) tablet 1 MG give 0.5 tablet by mouth at bedtime. 6/22/18 - Review of the INR/Coumadin (Warfarin) Flowsheet did not have an INR result documented for 6/22/18. The INR/Coumadin (Warfarin) Flowsheet, which documented INR results, was kept in a binder at the nurse's station. This was the source document the physician used to determine the appropriate dosage of Coumadin for each resident. Review of the eMAR revealed that an INR result of 2.3 was recorded for 6/22/18. 6/23/18 - The INR/Coumadin (Warfarin) Flowsheet documented an INR of 1.4. The eMAR	F 760	A. R114 was affected by this practice. R114 has been discharged. B. Current residents have the potential of being affected by this practice. Director of nursing or designee will audit current residents with lovenox orders to ensure PT/INR are obtained when indicated and administered per order. C. Director of nursing or designee will re-educate licensed nurses on ensuring residents with lovenox orders that require PT/INR are obtained and administered per order. D. Director of nursing or designee will audit current residents with lovenox orders to ensure physician orders PT/INR are obtained when indicated and administered per order. Audits will be completed daily x 5 days, weekly x 2, and monthly x 2 to ensure substantial compliance. Results will be provided to the Quality Assessment and Assurance Committee for review and action as appropriate up until 100% compliance is met. The committee will determine need for further audits and/or action plans.	

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F 760	Continued From page 53 documented an INR value of 2.3. The facility failed to identify this discrepancy. 6/24/18 - The INR/Coumadin (Warfarin) Flowsheet did not document an INR result. The eMAR documented an INR value of 2.3. 6/25/18 - Both the INR/Coumadin (Warfarin) Flowsheet and eMAR documented an INR of 1.4. There was no evidence Lovenox was administered. The 6/22/18 physician's order stated to give Lovenox when the INR was less than 2.0. 6/27/18 - The eMAR documented an INR result of 1.4. There was no evidence Lovenox was administered according to physician's orders. 6/28/18 - A physician's order stated INR daily every night shift until greater than 2, then every Monday and Thursday. 6/28/18 - The INR/Coumadin (Warfarin) Flowsheet, eMAR and eTAR documented an INR of 1.4. There was no evidence Lovenox was administered according to physician's orders. 6/29/18 - Both the INR/Coumadin (Warfarin) Flowsheet and eMAR documented an INR of 1.5. The eTAR documented an INR of 1.7. There was no evidence Lovenox was administered according to physician's orders. 6/30/18 - The INR/Coumadin (Warfarin) Flowsheet did not document an INR value. The eMAR documented an INR value of 1.5 and the eTAR a value of 1.7. There was no evidence Lovenox was administered according to physician's orders.	F 760		

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F 760	Continued From page 54 7/1/18 through 7/6/18 - Review of the INR/Coumadin (Warfarin) Flowsheet revealed INR values ranging from 1.3 to 1.7. There was no evidence that Lovenox was administered according to physician's orders on any of these days. 7/7/18 - The clinical record lacked evidence of an INR being completed on this day despite the physician's order from 6/28/18 to test daily until the INR value was greater than 2.0. The facility failed to follow the physician's order to administer Lovenox when the INR less than 2.0 on multiple days resulting in a significant medication error. Additionally, the facility failed to complete an INR on 7/7/18 when daily INRs were ordered. 10/2/18 approximately 3:00 PM - During an interview with E2 (DON), R114's INR/Coumadin (Warfarin) Flowsheet, eMAR, eTAR and physician's orders were reviewed. E2 confirmed that Lovenox was not administered according to physician's orders on multiple occasions and that the 7/7/18 INR was not completed. 10/2/18 approximately 7:15 PM - Findings were reviewed with E1 (NHA), E2 and E3 (ADON) during the exit conference.	F 760		
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	F 812		11/16/18

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F 812	Continued From page 55 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 observations and interview, it was determined that the facility failed to ensure that staff followed proper sanitation practices to prevent food contamination, when handwashing was not performed between activities and between glove changes, and when eating utensils were exposed to unclean surfaces. Findings include: During the initial kitchen tour on 9/20/18 at 9:00 AM, E22 was observed performing general cleaning in the serving area, wiping countertops and other surfaces with gloved hands. E22 then moved to the dish room to the area with newly washed items, wearing the same gloves worn earlier. E22 picked up a clean tray and wiped it with a kitchen towel before putting it away in a rack. E22 proceeded to transfer newly washed plate domes, coffee mugs and water tumblers to their respective racks while wearing the same gloves.	F 812	It is the intent of this facility to store prepare, distribute, and serve food in accordance with professional standards for food safety. A. E22 was educated to hand wash and change gloves between dirty and clean handling. Cellphone was removed. Identified Tray, plate domes, coffee mugs, and water tumblers, and teaspoons were rewashed. B. Dietary director or designee will conduct audit of kitchen to ensure personal staff items are not in contact with Utensils, Staff wash hands between glove application when moving between dirty and clean handling. C.Dietary director or designee will re-educate dietary staff on not placing personal items in contact with utensils,	

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F 812	Continued From page 56 At 10:40 AM on 9/20/18, E22 was observed in the dish room putting away clean utensils with gloved hands. Before removing the utensils from the rack coming out of the dishwasher, E22 took off the gloves and put on a fresh pair without first handwashing. A small, open rectangular tray containing teaspoons with a cellphone on top was also observed on the countertop opposite the dishwasher. At 10:45 AM, E22 was observed removing the cellphone from the tray and putting it in her pocket. Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 9/21/18 at 2:30 PM.	F 812	and handwashing between glove changes, in addition to glove changes when moving between dirty and clean handling. D. NHA or Designee will audit Kitchen to ensure staff are changing gloves between dirty and clean handling, washing hands between glove changes, and not placing personal items in contact with utensils. Audits will be completed daily x 5 days, weekly x 2, and monthly x 2 to ensure substantial compliance. Results will be provided to the Quality Assessment and Assurance Committee for review and action as appropriate up until 100% compliance is met. The committee will determine need for further audits and/or action plans.	
F 814 SS=D	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observations and interview, it was determined that the facility failed to ensure that the outdoor dumpster properly covered the bagged garbage contained inside to prevent the harborage of pests. Findings include: On 9/20/18 at 8:00 AM, 9:45 AM and 2:15 PM, the outdoor dumpster was observed with bags of trash piled on top preventing the dumpster cover from closing. In addition, the dumpster at 8:00 AM was overflowing with bagged trash, bags were hanging over the dumpster's sides.	F 814	It is the intent of this facility to dispose of refuse and garbage properly. A. Garbage lid was closed when identified. B. NHA or designee will conduct dumpster area rounds to ensure lid is covering the trash. C. NHA or designee will re-educate Maintenance director and Dietary staff to	12/16/18

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F 814	Continued From page 57 Findings were reviewed with E1 (NHA) and E2 (DON) during an exit conference on 9/21/18 at 2:30 PM.	F 814	ensure lid on dumpster is present and covering trash. D. NHA or designee will audit dumpsters to ensure lids on and covering trash. Audits will be completed daily x 5 days, weekly x 2, and monthly x 2 to ensure substantial compliance. Results will be provided to the Quality Assessment and Assurance Committee for review and action as appropriate up until 100% compliance is met. The committee will determine need for further audits and/or action plans.	
F 947 SS=D	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced	F 947		11/16/18

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MANORCARE HEALTH SERVICES - WILMINGTON	700 FOULK ROAD WILMINGTON, DE 19803

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F 947	Continued From page 58 by: Based on interview and review of facility documentation, it was determined that for two (E4 and E24) out 6 CNA's the facility failed to provide the required in-service training for nurse aides. Findings include: The facility was provided a list of 6 CNA names selected at random, and were instructed to provide documentation showing when the employees had dementia training. The documentation revealed that E4 (CNA) and E24 (CNA) did not have dementia training. Findings were reviewed with E1 (NHA) and E2 (DON) on 10/1/18 at approximately 5:10 PM.	F 947	It is the intent of this facility provide dementia training for CNAs. A. E4 and E24 were provided dementia training. B. NHA or designee will conduct audit of CNA dementia training to ensure CNAs have received required annual training. C. NHA or designee will re-educate Staff development coordinator and Human Resources Director to ensure CNAs receive dementia training annually. D. NHA or designee will audit Current CNA education to ensure dementia training has been completed annually. Audits will be completed daily x 5 days, weekly x 2, and monthly x 2 to ensure substantial compliance. Results will be provided to the Quality Assessment and Assurance Committee for review and action as appropriate up until 100% compliance is met. The committee will determine need for further audits and/or action plans.	

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

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

AME OF FACILITY: ManorCare Health Services – Wilmington

DATE SURVEY COMPLETED: October 2, 2018

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	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 October 2, 2018: F550, F558, F637, F645, F656, F658, F677, F679, F686, F688, F689, F695, F756, F757, F760, F812, F814, and F947.		
3201.5.6	**Dementia Training**		
3201.5.6.1	**Nursing facilities that provide direct healthcare services to persons diagnosed as having Alzheimer's disease or other forms of dementia shall provide dementia specific training each year to those healthcare providers who must participate in continuing education programs. This section shall not apply to persons certified to practice medicine under the Medical Practice Act, Chapter 17 of Title 24 of the Delaware Code.** Based on record review it was determined that the facility failed to ensure that one (E23 -LPN) out of 6 employees reviewed received annual dementia training. Findings include: The facility lacked evidence that E23 was provided dementia training. Findings were reviewed on 10/2/18, at approximately 7:10 PM with E1 (NHA), E2 (DON), and E3 (ADON) during the exit conference.	A. E23 was provided dementia training. B. NHA or designee will conduct audit of licensed nurse dementia training to ensure licensed nurses have received required annual training. C. NHA or designee will re-educate Staff development coordinator and Human Resources Director to ensure licensed nurses receive dementia training annually. D. NHA or designee will audit Current licensed nurse education to ensure dementia training has been completed annually. Audits will be completed daily x 5 days, weekly x 2, and monthly x 2 to ensure substantial compliance. Results will be provided to the Quality Assessment and Assurance Committee for review and action as appropriate up until 100% compliance is met. The committee will determine need for further audits and/or action plans.	11/16/18

ovider's Signature _____ Title NHA Date 11/16/18