

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

PRINTED: 01/22/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085028	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/25/2019
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES - WILMINGTON			STREET ADDRESS, CITY, STATE, ZIP CODE 700 FOULK ROAD WILMINGTON, DE 19803		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
E 000	Initial Comments An unannounced annual and complaint survey was conducted at this facility from November 18, 2019 through November 25, 2019. The facility census the first day of the survey was 124. During this period an Emergency Preparedness Survey was also conducted by the State of Delaware's Division of Health Care Quality Long Term Care Residents Protection in accordance with 42 CFR 483.73. For the Emergency Preparedness survey, no deficiencies were cited.	E 000			
F 000	INITIAL COMMENTS An unannounced annual, complaint and emergency preparedness survey was conducted at this facility from November 18, 2019 through November 25, 2019. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other documentation as indicated. The facility census the first day of the survey was 124. The survey sample size was 44. Abbreviations/Definitions: ADON - Assistant Director of Nursing; ADL (Activities of Daily Living) - tasks needed for daily living, e.g. dressing, hygiene, eating, toileting, bathing; CNA - Certified Nurse Aide; Contact Precautions - series of procedures used to minimize the transmission of infectious organisms by direct or indirect contact, such as wearing gloves and a gown; DON - Director of Nursing;	F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

12/19/2019

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 EMR - Electronic Medical Records; F - Fahrenheit/temperature scale; FSBS (Fingerstick Blood Sugar) - a test to determine blood sugar; FSD - Food Service Director; Gastric contents - digestive fluids secreted by the stomach; Gastric tube/Feeding tube - a tube placed directly into the stomach for the purposes of providing nutrition; Hoyer Lift - sling-type hydraulic lift; LPN - Licensed Practical Nurse; MDS - Minimum Data Set/standardized assessment forms used in nursing homes; NHA - Nursing Home Administrator; PPE - Personal Protective Equipment/gowns, gloves, mask worn to minimize exposure to infectious organisms. QAC - Quality Assurance Consultant.	F 000			
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 observations, record reviews, and interviews, it was determined that the facility failed to provide the necessary services to maintain good nail grooming for one (R4) resident who was unable to carry out activities of daily living, out of 44 sampled residents. Findings include: Review of R4's clinical record revealed:	F 677	The Statements made on this plan of 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	1/6/20	

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F 677	<p>Continued From page 2</p> <p>10/17/16 - R4 was admitted to the facility with diagnoses that included left sided paralysis.</p> <p>8/28/19 - R4's care plan was reviewed for the problem that R4 had a self care deficit and was unable to perform ADL's independently. Approaches included to assist R4 with daily hygiene and grooming.</p> <p>11/3/19 - A quarterly MDS assessment stated that R4 required extensive assistance with personal hygiene, which included nail trimming.</p> <p>11/18/19 at 10:08 AM - During an interview, it was observed that R4's fingernails were long and some were broken. R4 stated that he wanted his fingernails cut. R4 stated that staff used to cut his nails, but in the past few months his fingernails haven't been cut.</p> <p>11/19/19 at 11:30 AM - During an interview, E2 (DON) stated that the expectation for nail care is that it would be done as needed.</p> <p>11/19/10 at 1:56 PM - During an interview, E9 (CNA) stated that he checked R4's fingernails weekly to see if they needed to be trimmed. E9 stated that many times R4 would refuse to have his nails cut. The surveyor and E9 went into R4's room and R4 agreed to have his fingernails trimmed.</p> <p>The facility failed to provide nail care for R4, a resident who was unable to carry out ADL's.</p> <p>Findings were reviewed with E1 (NHA) and E2 (DON) on November 25, 2019 at 3:30 PM, during the exit conference.</p>	F 677	<p>deficiencies have been or will be corrected by the date or dates indicated.</p> <p>It is the intent of this facility to provide a resident who is unable to carry out activities of daily living, the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>A. R4 nails were trimmed on 11/19/19</p> <p>B. Current residents have the potential of being affected by this practice. Director of nursing or designee will audit current dependent residents to determine if nail care is needed.</p> <p>C. Director of nursing or designee will reeducate licensed Nurses and CNAs to ensure dependent residents nails are trimmed.</p> <p>D. Director of nursing or designee will audit dependent residents to ensure nails are trimmed. Audits will be completed weekly x 2, and monthly x 2. 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.</p>		

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F 693 F 693 SS=D	Continued From page 3 Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and review of the facility policy and procedure as indicated, the facility failed to ensure that one (R74) out of two residents sampled who were fed by enteral means, received the appropriate treatment and services to prevent complications. Facility staff were checking placement of the gastric tube using a method no longer considered the standard of practice. Findings include: Review of the following current standards of practice for tube placement verification revealed	F 693 F 693	It is the intent of this facility to ensure a resident who is fed by enteral means receives the appropriate treatment and services oral eating skills and to prevent complication of enteral feeding. A. R74 was not affected by this practice. B. Current resident who require medication administration via enteral tube have the potential of being affected by this practice.		1/6/20

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F 693	<p>Continued From page 4 that auscultation was no longer recommended:</p> <ul style="list-style-type: none"> - "Auscultation verification of gastric tube (feeding tube) placement solely by auscultation (listening), which involves instillation of air into the tube while simultaneously listening with a stethoscope over the epigastric (abdominal) region for the sound of air, is no longer recommended." (Emergency Nurses Association, Clinical Practice Guidelines: Gastric Tube Placement Verification, 2017). - " Nurses should not use the auscultatory (air bolus) ..." (American Association of Critical-Care Nurses updates Practice Alert on feeding tube placement 4/1/16). <p>Review of the facility's policy and procedure titled Enteral Tubes: Residual Checks and Irrigations/Flushes, dated 2/2012 indicated that the staff would verify proper placement of a feeding tube by aspirating gastric content.</p> <p>1. During a medication pass observation on 11/20/19 at approximately 1:59 PM, E11 (LPN) was observed administering medication via R74's feeding tube.</p> <p>E11 auscultated R74's abdomen using a stethoscope while injecting air with a syringe. E11 failed to aspirate gastric contents to verify placement of the feeding tube according to current standards of practice before administering the medication.</p> <p>2. 11/20/19 2:55 PM - An interview with E12 (LPN, Nurse Supervisor) revealed to verify proper placement of a enteral tube, E12 would instill 30 cc of air into the tube while listening with a</p>	F 693	<p>C. Director of Nursing or Designee will re-educate licensed nurses on verifying placement of enteral tubes prior to medication administration.</p> <p>D. Director of Nursing or designee will audit residents with medication administration via enteral tube to validate proper technique is used to verify enteral tube placement prior to administering medication. Audits will be completed weekly x 2, and monthly x 2. 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.</p>		

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F 693	Continued From page 5 stethoscope over the abdominal region for a sound of air. 11/21/19 1 PM - Findings were reviewed with E 2 (DON), E 5 (ADON), and E 3 (AC). E 2 confirmed to verify proper placement of a feeding tube prior to medication administration, the staff must aspirate gastric content.	F 693			
F 804 SS=D	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, anonymous resident interview and discussion during a surveyor-held Resident Council Meeting, it was determined that for one out of two meal test trays, the facility failed to provide food and drink that were served at appetizing temperatures. Findings include: 11/18/19 at 1:25 - During an interview, a resident, who wished to remain anonymous, stated that the food was always cold when served in the resident's room.	F 804	It is the intent of this facility to serve food and drink that is palatable, attractive and at a safe and appetizing temperature. A. No resident was affected as it a test tray. B. Current residents have the potential to be affected by this practice. C. NHA or Designee will reeducate nursing staff to deliever meals to residents	1/6/20	

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F 804	Continued From page 6 11/19/19 at 10:42 AM - During the surveyor-held Resident Council Meeting, it was discussed that the food served in rooms was not hot. 11/19/19 from 11:34 AM to 12:03 PM - An observation on the Heritage hallway revealed that after all residents were served their lunch meal trays to their rooms, the food and beverages on the meal test tray were checked for temperatures by E4 (FSD) using the facility's thermometer. The following were identified: - chicken with sauce was 134 degrees F; - pasta was 126 degrees F; - mix of cauliflower and broccoli was 130 degrees F; and - carton of whole milk was 48.2 degrees F. The surveyor tasted the food and drink and determined that the chicken, pasta, cauliflower and broccoli mix and milk were not served at appetizing temperatures. 11/19/19 at 12:03 PM - Findings were reviewed with E4 (FSD). The facility failed to provide food and drink that were served at appetizing temperatures. 11/25/19 at 3:20 PM - Findings were reviewed during the Exit Conference with E1 (NHA), E2 (DON) and E3 (Corporate Nurse).	F 804	timely upon arrival to unit to ensure meals are served at palatable and appetizing temperature. D. NHA or designee will conduct audit of 3 test trays per week x 2 weeks (1 Breakfast, 1 lunch, 1 Dinner), then 6 test trays monthly x 2 months (2 Breakfast, 2 Lunch, 2 Dinner) to ensure meals are served at palatable and appetizing temperature. Results will be provided to the Quality Assurance and Performance Improvement Committee for review and action as appropriate up until 100% of compliance is met. The committee will determine need for further audits and/ or action plans.		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent	F 842		1/6/20	

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F 842	<p>Continued From page 7</p> <p>agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.</p> <p>§483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-</p> <ul style="list-style-type: none"> (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized <p>§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-</p> <ul style="list-style-type: none"> (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. <p>§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.</p> <p>§483.70(i)(4) Medical records must be retained</p>	F 842			

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F 842	<p>Continued From page 8</p> <p>for-</p> <p>(i) The period of time required by State law; or</p> <p>(ii) Five years from the date of discharge when there is no requirement in State law; or</p> <p>(iii) For a minor, 3 years after a resident reaches legal age under State law.</p> <p>§483.70(i)(5) The medical record must contain-</p> <p>(i) Sufficient information to identify the resident;</p> <p>(ii) A record of the resident's assessments;</p> <p>(iii) The comprehensive plan of care and services provided;</p> <p>(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;</p> <p>(v) Physician's, nurse's, and other licensed professional's progress notes; and</p> <p>(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview it was determined for one (R83) out of one resident reviewed for ADL decline, the facility failed to ensure that accurate documentation was recorded. Findings include:</p> <p>7/19/19 - A Physical Therapy Discharge Summary listed R83's transfer skills as "Max," meaning maximum assistance required.</p> <p>8/21/19 - An ADL care plan was updated to include the intervention of "Transfer with mechanical-hoyer lift and 2 person assist..."</p> <p>10/9/19 - A quarterly MDS assessment documented R83 as totally dependent for transfers with two or more persons physically assisting.</p>	F 842	<p>It is the intent of this facility to maintain medical records on each resident that are complete, accurately documented, readily accessible, and systematically organized.</p> <p>A. R83 was not affected by this deficient practice.</p> <p>B. Current residents who require use of a mechanical lift for transfers have the potential to be affected by this practice. Director of Nursing or Designee will audit current residents who require a mechanical lift for transfers to determine transfer status is accurately documented.</p> <p>C. Director of Nursing or designee will re-educate licensed nurses and CNAs to</p>		

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F 842	<p>Continued From page 9</p> <p>September 2019 - Review of the Documentation Survey Report (report where CNAs record their documentation) revealed that in September, R83 was transferred a total of 26 times, and 19 of these transfers were done with less than two staff members assisting.</p> <p>October 2019 - Review of the Documentation Survey Report revealed that in October, R83 was transferred a total of 29 times, and 18 of these transfers were done with less than two staff members assisting.</p> <p>November 1 - 19, 2019 - Review of the Documentation Survey Report revealed that in November, R83 was transferred a total of 23 times, and 7 of these transfers were done with less than two staff members assisting.</p> <p>11/20/19 - R83's bedside Kardex Report (posted at the bedside for CNAs to reference during care) documented, "Transfer with mechanical-hoyer lift and 2 person assist."</p> <p>11/21/19 11:55 AM - During an interview, E6 (CNA), one of R83's regular care givers, stated that R83 required "total" assistance using "a hoyer and two people."</p> <p>11/21/19 12:22 PM - During an interview, E5 (ADON) was shown the Documentation Survey Reports and Kardex Report. E5 stated that an investigation would be conducted to discover why staff members documented anything less than two staff members were used doing R83's transfers.</p> <p>11/21/19 1:30 PM - During an exit conference</p>	F 842	<p>accurately document transfer status of residents who require a mechanical lift.</p> <p>D. Director or Nursing or designee will audit residents who use a mechanical lift to validate transfer status is accurately documented. Audits will be completed weekly x 2, and monthly x 2. 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.</p>		

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F 842	Continued From page 10 with E2 (DON) and E3 (ADON), E3 stated that after interviewing most staff members, it was determined that this concern was a problem with documentation by the CNAs. All staff members interviewed replied that when a hooyer was used for transfers, two staff members assisted. E3 stated this was how staff members are trained to operate the hooyer lift. 11/25/19 - Written statements from 13 out of 13 staff members stated that R83 was transferred with the assistance of two people.	F 842			
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual	F 880		1/6/20	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES - WILMINGTON			STREET ADDRESS, CITY, STATE, ZIP CODE 700 FOULK ROAD WILMINGTON, DE 19803		
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F 880	<p>Continued From page 11</p> <p>arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv) When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and</p> <p>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and</p>	F 880			

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F 880	<p>Continued From page 12</p> <p>transport linens so as to prevent the spread of infection.</p> <p>§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations, interview and review of facility policies, it was determined that the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Observations of facility staff and a visitor revealed deficient practices in the areas of hand hygiene, the use of personal protective equipment (PPE), and ensuring a visitor was educated on and followed the facility's infection control procedures. Findings include:</p> <p>Review of the facility's Infection Control Manual Chapter 2 - Practice Guidelines, Section 3, Basic Concepts, Hand Hygiene, dated 2013, indicated "...Guidelines for Hand Hygiene...Handwashing with soap and water: wet hands and wrists with water, apply soap and lather using a rotating motion and friction to adequately clean surfaces including backs of the hands and finger nails for at least 15 seconds..."</p> <p>1. An observation on 11/19/19 at 11:53 AM revealed E4 (FSD) deliver a meal tray without applying appropriate PPE before entering R312's room, who was on Contact Precautions. An isolation cart with PPE was observed outside of R312's door and a sign was posted.</p>	F 880	<p>It is the intent of this facility to establish and maintain infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.</p> <p>A. E4, E11, and E12 were provided 1:1 counseling. R312 no longer resides at facility. At time of exit, facility did not have any patients on isolation precautions. E7 educated on facility policy regarding contaminated linens.</p> <p>B. Current residents have the potential of being affected by this practice.</p> <p>C. DON or designee will education licensed nurses, CNA, and dietary staff on proper hand hygiene and use of personal protective equipment for transmission-based precaution requirements. DON/ Designee will educate Family members of patients on isolation precautions on transmission-based precautions including hand hygiene and use of personal protective equipment. DON or designee will environmental services staff on facility policy of handling contaminated linens.</p>		

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F 880	<p>Continued From page 13</p> <p>11/25/19 at 3:20 PM - Finding was reviewed during the Exit Conference with E1 (NHA) and E2 (DON).</p> <p>2. An observation on 11/19/19 from 12:28 PM to 12:36 PM revealed a visitor remove a yellow PPE gown out of the isolation cart and carried the gown in her bare hand as she walked into R312's room, who was under Contact Precautions. At 12:29 PM, the visitor exited R312's room wearing the gown out into the hallway and walked toward the nurse's medication cart. The visitor's gown was not appropriately tied in the back and was falling off the visitor's shoulders. There was no evidence of hand washing/sanitizing prior to the visitor's exit of R312's room at 12:29 PM. The nurse, who remained at the medication cart, told the visitor to dispose of the yellow gown in the trash can in the resident's room. The visitor walked back to R312's room and disposed of the yellow gown. There was no evidence of hand washing after removal of the gown. The visitor immediately came back out into the hallway and retrieved a new yellow gown out of the isolation cart and went back into R312's room with the new gown in her hand. No gloves were observed being worn by the visitor who was at R312's bedside. At 12:36 PM, the visitor was observed wearing the yellow gown and leaning on R312's bed. The facility failed to immediately educate the visitor on all aspects of isolation precautions, including the proper application and disposal of PPE and hand hygiene, to ensure the visitor followed the facility's infection control procedures.</p> <p>11/25/19 at 3:20 PM - Findings were reviewed during the Exit Conference with E1 (NHA) and E2 (DON).</p>	F 880	D. Director of nursing or designee will audit adherence to hand hygiene, transmission-based precautions, and handling of contaminated linen weekly x 2, monthly x2. 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 880	<p>Continued From page 14</p> <p>3. During a random medication pass observation on 11/20/19 at 2:00 PM, E11 (LPN) turned on the faucet, placed her hands underneath the running water without soap, rubbed her hands for approximately 3 seconds, then proceeded to obtain a paper towel to dry her hands, turned off the water with the same paper towel and donned a pair of gloves. E11 performed a FSBS on R81. After performing FSBS, E11 removed gloves, turned on the faucet, placed her hands underneath the running water, began rubbing her hands without soap for approximately 2 seconds, then proceeded to dry her hands with a paper towel, and used the same paper towel to turn off the faucet. E11 failed to use soap during handwashing and failed to wash her hands for at least 20 seconds as per CDC (Centers for Disease Control and Prevention) guidelines.</p> <p>4. During a random medication pass observation on 11/21/19 at 11:21 AM, E12 (RN) applied hand wash (soap) and proceeded to immediately air dry her hands prior to donning a new pair of gloves. E12 then performed a FSBS on R88. After the completion of the FSBS, E12 used hand wash (soap) and air dried her hands. An interview with E12 immediately after this observation revealed that she thought the hand wash was a hand sanitizer. E12 confirmed the dispenser that she utilized was hand wash (soap) and not a hand sanitizer. After using soap, E12 failed to wash her hands using running water for at least 20 seconds as per CDC guidelines.</p> <p>5. 11/25/19 at 11:10 AM - During a tour of the</p>	F 880			

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F 880	<p>Continued From page 15</p> <p>laundry area, E7 (Housekeeping Director) stated he is informed by nursing when a resident is on isolation and isolation laundry is done last. E7 stated that nursing staff labeled the soiled linen bag with the resident's room number to alert laundry staff that that particular soiled linen was from an isolation room.</p> <p>11/25/19 at 11:18 AM - During an interview, E8 (CNA) stated that soiled linen from an isolation room would be placed in the soiled linen room. E8 stated that she does not label the soiled linen bag in any way.</p> <p>11/25/19 at 11:47 AM - During an interview, E10 (CNA) stated that soiled linen from an isolation room would be placed in the hampers in the soiled linen room. E10 stated that she does not label the soiled linen bag in any way.</p> <p>Review of CDC guidelines for laundry (https://www.cdc.gov/infection-control/guidelines/environmental/background/laundry.html), revealed that "bags containing contaminated laundry must be clearly identified with labels, color-coding, or other methods so that health-care workers handle these items safely."</p> <p>The facility failed to have a process or policy to label contaminated linen in order to alert laundry staff that the linen was from a resident on isolation precautions.</p> <p>Findings were discussed with E1 (NHA) and E2 (DON) on November 25, 2019 at 3:30 PM, during the exit conference.</p>	F 880			



DELAWARE HEALTH AND SOCIAL SERVICES

Division of Long Term Care
Residents Protection

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

STATE SURVEY REPORT

NAME OF FACILITY: Manor Care Health Services Wilmington DATE SURVEY COMPLETED: November 25, 2019

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
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3201	<p>The State Report incorporates by reference and also cites the findings specified in the Federal Report.</p> <p>An unannounced annual, complaint and emergency preparedness survey was conducted at this facility from November 18, 2019 through November 25, 2019. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other documentation as indicated. The facility census the first day of the survey was 124. The survey sample size was 44.</p>	<p>Plan of corrections Submitted for</p> <p>F 677 1/6/20</p> <p>F 693 1/6/20</p> <p>F 804 1/6/20</p> <p>F 842 1/6/20</p> <p>F 880 1/6/20</p>
3201.1.0	<p>Regulations for Skilled and Intermediate Care Facilities</p> <p>Scope</p>	
3201.1.2	<p>Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.</p>	
	<p>This requirement is not met as evidenced by: Cross-refer to CMS 2567-L survey completed November 25, 2019: F677, F693, F804, F842, and F880.</p>	

Provider's Signature

Title

NIA

Date

1/2/19