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

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

STATE SURVEY REPORT

NAME OF FACILITY: Pinnacle Rehabilitation & Health Center **DATE**
SURVEY COMPLETED: April 11, 2023

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
3201	**The State Report incorporates by reference and also cites the findings specified in the Federal Report.** An unannounced Annual and Complaint Survey was conducted at this facility from April 3, 2023, through April 11, 2023. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census on the first day of the survey was 124 residents. The investigative sample totaled 37 residents.		
3201.1.0	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.2	**Scope** **Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** This requirement is not met as evidenced by: Cross Refer to the CMS 2567-L survey completed April 11, 2023: F584, F623, F677, F684, F698, F730, F755, F759, F760, F790, F812 and F887.	Please Cross Refer to the CMS 2567-L survey ending April 11, 2023 responses posted on ePOC: F584, F623, F677, F684, F698, F730, F755, F759, F760, F790, F812 and F887.	06/06/2023

Provider's Signature Mary Ann D. Amos, NHA Title Administrator Date 5/15/23

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	085020	A. BUILDING _____ B. WING _____	C 04/11/2023

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PINNACLE REHABILITATION & HEALTH CENTER	3034 SOUTH DUPONT BLVD SMYRNA, DE 19977

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E 000	Initial Comments An unannounced Annual and Complaint Survey was conducted at this facility from 4/3/23 through 4/11/23. The facility census was 124 on the first day of the survey. In accordance with 42 CFR 483.73, an Emergency Preparedness Survey was also conducted by The Division of Health Care Quality, Office of Long-Term Care Residents Protection at this facility during the same time period. Based on observations, interviews, and document review, no Emergency Preparedness deficiencies were found.	E 000		
F 000	INITIAL COMMENTS An unannounced Annual and Complaint Survey was conducted at this facility from April 3, 2023 through April 11, 2023. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census on the first day of the survey was 124 residents. The investigative sample totaled 37 residents. Abbreviations/definitions used in this report are as follows: ADON - Assistant Director of Nursing; CNA - Certified Nursing Assistant; DON - Director of Nursing; LPN - Licensed Practical Nurse; NHA - Nursing Home Administrator; RN - Registered Nurse; SSD - Social Services Director; WCN - Wound Care Nurse; WCNP - Wound Care Nurse Practitioner;	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/05/2023

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 Alzheimer's Disease - degenerative disorder that attacks the brain's nerve cells resulting in loss of memory, thinking and language; Anxiety - general term for several disorders that cause nervousness, fear, apprehension and worrying or Anxiety is an unpleasant state of inner turmoil, often accompanied by nervous behavior, such as pacing back and forth; AV fistula (arteriovenous fistula) - a type of dialysis access; a surgical connection made between an artery and a vein, created by a vascular specialist typically located in the arm or in the leg where blood flows from the artery directly into the vein; Benign prostate - enlargement of the male prostate gland; Catheter - a small tube used to drain fluid; Erythema- superficial reddening of the skin; Hemodialysis - procedure that removes waste and extra fluid from the body through the blood; MDD (Major Depressive Disorder) - also known as depression, is a mental disorder characterized by at least two weeks of low mood that is present across most situations. It is often accompanied by low self-esteem, loss of interest in normally enjoyable activities, low energy, and pain without a clear cause; Medication Regimen Review (MRR) - monthly review by Pharmacist of resident's medications, laboratory tests and any records necessary to determine whether or not irregularities exist; MEQ (Milliequivalent) - Unit of weight; Mg (Milligram(s) - Unit of weight; Minimum Data Set (MDS) - standardized assessment forms used in nursing homes; Neuromuscular dysfunction of the bladder - issues with the bladder frequency, urgency and retention;	F 000		

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F 000	Continued From page 2 Parkinson's Disease - a progressive disorder of the nervous system that affects your movement or a disorder of the brain that leads to shaking (tremors) and difficulty with walking, movement, and coordination; Pressure Ulcers (PUs) - sore area of skin that develops when the blood supply to it is cut off due to pressure; SBAR (Situation Background Assessment Recommendation) - tool used to communicate between members of the healthcare team; Tamsulosin - medication used to treat benign prostate disease; Ulcer- an open sore on an external or internal surface of the body, caused by a break in the skin or mucous membrane that fails to heal; Vesicle - circumscribed elevation of skin filled with serous fluid (herpes simplex or chicken pox).	F 000		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss	F 584		6/6/23

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F 584	Continued From page 3 or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on interview and observation of one out of two units toured, it was determined that the facility failed to provide a clean and homelike environment. Findings include: 4/6/23 1:37 PM - An observation on the Sierra unit revealed the following: black matter in the shower stall to the back right, black matter on the shower curtain, and a brown substance caking up the drain. 4/10/23 9:24 AM - An interview with E18 (Housekeeping) revealed there was not a set schedule to clean the shower rooms, however, E18 said that the showers could be cleaned daily.	F 584	A. Sierra Unit□s shower room was cleaned. Observed black matter on shower stall and shower curtain was corrected on 4/11/23, and discolored concrete on drain will be corrected. E18 was educated on maintaining a clean and homelike environment. B. Showers rooms in the two remaining units were inspected. No other deficiencies were noted on shower stalls, shower curtains or drain. C. The root cause was determined to be	

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F 584	Continued From page 4 Observation in the shower room with E18 confirmed there was "mildew and mold" in the shower, there was "build up" around the drain, and "build up" on the grout. Furthermore, E18 added that the shower room needs "to be scrubbed up." Findings were reviewed during the Exit Conference with E1 (NHA), E2 (DON), and E3 (Regional Nurse) on 4/11/23, at approximately 1:30 PM.	F 584	due to not having an established cleaning schedule in the shower room. A shower room cleaning schedule has been established to ensure it is cleaned routinely. Housekeeping Director/Designee will in-service housekeeping staff regarding shower room cleaning schedules and maintaining a clean and homelike environment. D. Daily audit by Housekeeping Director/Designee of shower rooms to ensure it is cleaned as scheduled x 7 days until 100% compliance is achieved and sustained. Following will be a weekly audit x 4 until a 100% compliance is achieved, then monthly x 3 months with a goal of 100% is achieved and sustained. In an event where compliance is consistently below the goal, the Interdisciplinary Team (IDT) will meet with the QA Committee to review the process and revision will be made to maintain and sustain compliance. Audit findings will be reported to QA committee monthly x 3 months.	
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and	F 623		6/6/23

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F 623	Continued From page 5 the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:	F 623		

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F 623	Continued From page 6 (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.	F 623		

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F 623	Continued From page 7 §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R49) out of three residents reviewed for hospitalization, the facility failed to ensure the Ombudsman was notified of the residents transfer to the hospital. Findings include: Review of R49's clinical record revealed: R49 was transferred to the hospital on 3/8/23 - 3/9/23 and then again on 3/23/23 - 3/25/23. 3/31/23 - E7 (SSD) sent an email of monthly transfer notices to the Ombudsman's office. R49's transfers were not listed on the notice. During an interview on 4/10/23 at 1:48 PM, E7 confirmed the finding. E7 reported she was unaware of the requirement to notify the Ombudsman of residents transferred to the hospital and was only providing notice of residents who were discharged. Findings were reviewed during the Exit Conference with E1 (NHA), E2 (DON), and E3 (Regional Nurse) on 4/11/23, at approximately 1:15 PM.	F 623	A. The facility corrected the March 2023 list of discharges to include R49□s transfer out to the hospital and submitted revised list to the Ombudsman 4/6/23. E7 will be educated by NHA/Designee regarding the requirement to notify the Ombudsman when residents are transferred to the hospital. B. Residents that are transferred to the hospital in the last 30 days will be reviewed to ensure an accurate list was sent to the Ombudsman per the Notice Requirements Before Transfer/Discharge. Any discrepancy will be corrected and clarified. C. The root cause was determined to be the lack of understanding of the social services staff of the Notice Requirements Before Transfer/Discharge to Ombudsman regarding hospital transfers. NHA/Designee will provide in-service to social services department regarding the Notice Requirements Before	

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F 623	Continued From page 8	F 623	Transfer/Discharge to Ombudsman. D. Monthly audit of the list for Ombudsman notification for discharged residents to the hospital will be reviewed by NHA/Designee until 100% compliance is achieved and sustained. Monthly audit will continue x 3 months. In an event where compliance is consistently below the goal, the Interdisciplinary Team (IDT) will meet with the QA Committee to review the process and revision will be made to maintain and sustain compliance. Audit findings will be reported to QA committee monthly x 3 months.	
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, interview, and record review, it was determined that for one (R98) out of five sampled residents for ADL's (activities of daily living), the facility failed to provide oral hygiene and grooming of facial hair for a resident that required extensive assistance. Findings include: A facility policy and procedure titled, "ADL Care" undated, documented: "To gather detailed information that will help to develop a plan of care that is appropriate for the resident in their ADL care; the process is continuous from admission	F 677	A. R98□s facial hair was groomed and oral hygiene need was provided to resident on 4/8/23 evening shift. E23 was educated on 4/8/23 regarding providing oral hygiene and grooming of facial hair for a resident that required extensive assistance. B. All active residents will be assessed for the need of grooming for facial hair and oral hygiene per individualized needs. Care will be provided as applicable.	6/6/23

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F 677	Continued From page 9 and continues until the resident is discharged. 4. Grooming and Dressing includes: As you provide the resident with personal care needs, you should note ...b. Assistance needed with bathing, hair, and nail care, dressing and undressing, mouth care." Review of R98's clinical record revealed: 2/1/21 - R98 was admitted to the facility with a diagnosis of Parkinson's Disease (a progressive disorder of the nervous system that affects movement or a disorder of the brain that leads to shaking (tremors) and difficulty in walking, movement, and coordination). 12/29/22 - R98's Annual MDS Assessment documented extensive assist of one staff for brushing his teeth and shaving. Review of R98's ADL care plan initiated on 2/1/21 (revised 1/3/23) revealed "assist with daily hygiene, grooming, dressing, oral care and eating as needed." 3/31/23 - R98's Quarterly MDS Assessment documented extensive assist of one staff was needed for brushing his teeth and shaving. 4/3/21 10:00 AM - A random observation and initial interview with R98 revealed he had long facial hair and moist caked food on and between his teeth. R98 said "Nobody brushed my teeth this morning." 4/5/23 10:48 AM - A second observation and interview with R98 revealed that oral care was not provided and R98 had not been shaved.	F 677	Staff will be educated regarding facial hair grooming and oral hygiene compliance. C. The root cause was determined to be due to lack of oversight of providing/assisting residents with grooming and oral hygiene needs routinely. Staff Development/Designee will in-service nursing, new hires and agency staff on routine grooming and oral hygiene care. Staff Dev/Designee will educate nursing management staff regarding hygiene oversight. D. Unit manager/Nursing supervisor to conduct observational rounds on 7-3 and 3-11 to assure that residents are provided grooming and oral hygiene daily x 7 days until 100% compliance is achieved and sustained. Following will be a weekly audit x 4, then monthly x 3 months with a goal of 100% is achieved and sustained. In an event where compliance is consistently below the goal, the Interdisciplinary Team (IDT) will meet with the QA Committee to review the process and revision will be made to maintain and sustain compliance. Audit findings will be reported to QA committee monthly x 3 months.	

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F 677	Continued From page 10 4/5/23 11:58 AM - During an observation and interview with E23 (CNA), E23 said "I gave him a bed bath and got him dressed; I didn't get a chance to shave him yet, but I'm going to." In addition, E23 said that she brushed R98's teeth this morning, E23 checked in R98's nightstand and dresser for a toothbrush, toothpaste and mouthwash which revealed that R98 did not have these items. E23 then stated "Oh, I forgot his gums were bleeding this morning, I threw the toothbrush out." E23 said that "she had not reported this to the nurse." E24 (LPN) said to E23 "You know where everything is in the storage room." E23 placed a new toothbrush, toothpaste, and mouthwash in R98's drawer. E24 asked E23 if she told R98's Nurse that his gums had been bleeding this morning. E23 replied "No, I did not." 4/6/23 9:28 AM - A repeat observation and interview with R98 revealed that R98 continued to have long facial hair and R98's toothbrush was still in an unopened wrapper. R98 said "No, my teeth were not brushed and I want to get shaved." 4/6/23 2:20 PM - Observed R98 in bed and unshaven. 4/11/23 Findings were reviewed with E1 (NHA), E2 (DON) and E3 (RN) during the Exit Conference, beginning at 1:15 PM.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure	F 684		6/6/23

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F 684	Continued From page 11 that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of other documentation, it was determined that for one (R128) out of one resident reviewed for skin conditions, the facility failed to initiate timely treatment to R128's pinky toe. Findings include: Review of R128's record revealed the following: 1/19/23 - R128 was admitted to the facility. 1/19/23 - An Admission MDS revealed that R128 was severely cognitively impaired, totally dependent on staff for bed mobility, transfers, toilet use, and eating, requiring extensive assistance of one person. 1/20/23 10:49 PM - An SBAR documented that R128 had a fluid filled blister on the right pinky toe. The facility lacked evidence of initiating a treatment to R128's right foot from 1/20/23 to 1/22/23, despite the above notification to the Physician. 1/22/23 - A treatment order was initiated for skin prep to both feet for blisters every shift. 1/24/23 8:39 AM - A review of progress notes revealed that R128 was evaluated by E25 (WCNP) who documented, "Right lateral foot fluid filled vesicle, left lateral foot fluid filled vesicle with what appears to be vascular changes noted to	F 684	A. Treatment order for R128 was initiated on 1/22/2023. No further corrective action required. The resident was discharged from the facility. Unable to correct the action. E14 was educated on 5/5/23 to ensure treatment orders are obtained timely for skin alteration as applicable. B. Active residents with skin alterations will be reviewed by wound care nurse/designee to ensure treatment orders are in place as applicable. C. The root cause was determined to be due to the licensed staff□s understanding of the process when a skin alteration is identified. Staff Development/Designee will in-service licensed staff, new hires and agency staff regarding the process to follow when a skin alteration is identified. D. Daily audit by the WCN/Designee to ensure skin alterations identified has appropriate treatment order in place x 7 days until 100% compliance is achieved and sustained. Following will be a weekly audit x 4, then monthly x 3 months with a goal of 100% is achieved and sustained. In an event where compliance is	

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F 684	Continued From page 12 the lateral foot and left fourth and fifth toes." 4/10/23 9:30 AM - An interview with E14 (WCN), confirmed that fluid filled vesicles (blisters) were identified on 1/20/23 and treatment was initiated on 1/22/23. E14 assessed R128 on 1/23/23 for the new skin condition identified. E14 reviewed the orders during the interview and confirmed that a treatment was not ordered until two days later. E14 also revealed that if a skin condition arises during a weekend the area would not be assessed until Monday when E14 returns to work. 4/10/23 10:00 AM - An interview with E15 (LPN) confirmed that R128 had active skin treatments in place before she was discharged from the facility. Findings were reviewed during the Exit Conference with E1 (NHA), E2 (DON), and E3 (Regional Nurse) on 4/11/23, at approximately 1:15 PM.	F 684	consistently below the goal, the Interdisciplinary Team (IDT) will meet with the QA Committee to review the process and revision will be made to maintain and sustain compliance. Audit findings will be reported to QA committee monthly x 3 months.	
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that for one (R15) out of one resident reviewed for dialysis, the facility failed to monitor the residents dialysis catheter. Findings include: 6/12/21 - R15 was admitted to the facility.	F 698	A. R15□s dialysis site catheter care was ordered on 4/6/2023. E16 and E17 were educated to assure that physician orders are obtained for assessment and monitoring of residents	6/6/23

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F 698	Continued From page 13 6/14/21 - A care plan initiated for R15's dependency on hemodialysis revealed that the AV fistula (dialysis catheter in arm) should be checked per Physician's order and any abnormalities are to be reported to the Physician. 4/6/23 - A review of R15's Physicians orders lacked evidence of an order to check R15's dialysis catheter. 4/6/23 10:35 AM - An interview with R15 revealed that staff do not assess the dialysis catheter before leaving the facility or upon return from dialysis. 4/6/23 10:40 AM - An interview with E16 (LPN) confirmed that staff do not assess the dialysis catheter pre and post dialysis. 4/6/23 10:50 AM - An interview with E17 (LPN UM) confirmed there was no Physician's order to assess the dialysis catheter. Findings were reviewed during the Exit Conference with E1 (NHA), E2 (DON), and E3 (Regional Nurse) on 4/11/23, at approximately 1:15 PM.	F 698	dialysis catheter. B. Active residents receiving Dialysis will be reviewed to ensure physician orders reflect assessment and monitoring of residents dialysis catheter C. The root cause was determined to be due to staff failing to obtain an order for monitoring of the dialysis site on readmission. Staff Development/Designee will in-service licensed nurse/new hires and agency staff to ensure physician orders are obtained for assessment and monitoring of residents dialysis catheter for dialysis residents and reviewed with new admissions/readmissions. D. Daily audit of new admissions/readmissions receiving dialysis will be conducted by DON/Designee to ensure physician orders are noted for assessment and monitoring of residents dialysis catheter daily x 7 days until 100% compliance is achieved and sustained. Following will be a weekly audit x 4, then monthly x 3 months with a goal of 100% is achieved and sustained. In an event where compliance is consistently below the goal, the Interdisciplinary Team (IDT) will meet with the QA Committee to review the process and revision will be made to maintain and sustain compliance. Audit findings will be reported to QA committee monthly x 3 months.	

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F 730 SS=D	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on review of facility documentation and interview, it was determined that for six (E8, E9, E10, E11, E12 and E21) out of six employee evaluations reviewed, the facility failed to ensure that performance evaluations were conducted every 12 months. Findings include: 1. E8 was due for an evaluation on 11/3/22 and it was not conducted until 2/25/23. 2. E9 was due for an evaluation on 8/14/22 and it was not conducted until 1/29/23. 3. E10 was due for an evaluation on 7/2/22 and it was not conducted until 2/3/23. 4. E11 was due for an evaluation on 8/6/22 and it was not conducted until 2/1/23. 5. E12 was due for an evaluation on 9/10/22 and it was not conducted until 2/3/23. 6. E21 was due for an evaluation on 4/7/22 and it was not conducted until 2/1/23. During an interview with E13 (Human Resources) on 4/11/23 at 10:00 AM, E13 acknowledged that the six performance evaluations were late.	F 730	A. Unable to correct the action. B. All active nurse□s aide files will be reviewed by Human Resources Director/Designee to ensure performance evaluations are completed on every nursing assistant at least once every 12 months. Staff identified not current will be reviewed and appraisal completed. C. The root cause was determined to be due to lack of management oversight of timely completion of performance evaluations. NHA/Designee will in-service Human resources and nursing management staff on the requirement to ensure performance evaluations are completed on every nursing assistant at least once every 12 months and the written expectation of the performance review. Performance reviews will address staff meeting the required twelve hours of in-service training per year. Performance reviews will also address areas/weaknesses in which the staff can	6/6/23

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F 730	Continued From page 15 Findings were reviewed with E1 (NHA), E2, (DON) and E3 (Regional Nurse) during the exit conference, beginning at approximately 1:15 PM.	F 730	improve on so that further education and competency can be achieved. D. Weekly audit by HR/Designee will be conducted to assure that performance evaluations are scheduled and completed based on requirement weekly x 4 weeks until a 100% compliance is achieved, then monthly x 3 months with a goal of 100% is achieved and sustained. In an event where compliance is consistently below the goal, the Interdisciplinary Team (IDT) will meet with the QA Committee to review the process and revision will be made to maintain and sustain compliance. Audit findings will be reported to QA committee monthly x 3 months.	
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure that it was free of a medication error rate of 5% or greater. Medication pass observations identified three (3) errors out of twenty-six (26) opportunities, resulting in a medication error rate of 11.5%. Findings include: Cross refer to F760	F 759	A. R116 was assessed by E20 at the time of medication error identification on 4/5/23. There is no adverse effect to R116 related to the deficient practice. NP performed medication review and changed medications to a crushable or liquid state as appropriate for administration 4/6/23. Facility unable to correct due to resident is no longer in the building.	6/6/23

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F 759	Continued From page 16 Review of R116's clinical record revealed: 1/2/23 - A Physician's order was written for Galantamine Hydrobromide 8 mg, give two tablets (tabs) by mouth daily related to Alzheimer's Disease. 1/3/23 - Physician's orders were written for Potassium Chloride 20 MEQ Extended Release, give one tab by mouth daily for nutritional supplementation and for Levetiracetam 500 mg, give one tab by mouth twice a day for seizures. 4/5/23 9:00 AM - During a random medication pass observation, E20 (RN) administered the above medications to R116 after crushing the medications. 4/5/23 10:30 AM - During an interview, E20 confirmed that the medication instructions for Galantamine Hydrobromide, Potassium Chloride Extended Release and Levetiracetam stated the medications should not have been crushed. Findings were reviewed with E1 (NHA), E2 (DON) and E3 (Regional Nurse) during the exit conference, beginning at approximately 1:15 PM.	F 759	E20 was educated regarding medications that cannot be crushed on 4/5/23. B. A list of medications that cannot be crushed was provided to the licensed nursing staff. C. The root cause is determined to be due to the licensed nurse lack of understanding of medications that cannot be crushed. Staff Development/Designee will in-service licensed nurse/new hires/agency staff of medications on the do not crush list. D. Random audits x 7 days by DON/Designee of staff on multiple shifts during medication pass observations will be conducted to assure that staff adheres to the do not crush list until 100% compliance is achieved and sustained. Following will be a weekly audit x 4, then monthly x 3 months with a goal of 100% is achieved and sustained. In an event where compliance is consistently below the goal, the Interdisciplinary Team (IDT) will meet with the QA Committee to review the process and revision will be made to maintain and sustain compliance. Audit findings will be reported to QA committee monthly x 3 months.	
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2)	F 760		6/6/23

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F 760	Continued From page 17 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 observation and staff interview, it was determined that the facility failed to ensure that one (R116) out of eight (8) sampled residents reviewed for medication (med) review was free from significant medication errors. During a med pass observation, R116 was administered three oral meds in a crushed form that did not follow the manufacturer's instructions to not crush the meds prior to administration. Findings include: Galantamine Hydrobromide tablet is an enteric coated tablet; crushing enteric coated tablets releases the drug into the stomach where it may be destroyed by stomach acid and not be absorbed into the body. Potassium Chloride is an Extended Release tablet, designed to slowly release the drug in the body over an extended period of time instead of all at once when crushed; high potassium levels may cause life threatening heart rhythm problems, muscle weakness and/or paralysis. Crushing Levetiracetam tablets can produce a bad taste in the mouth. Review of R116's clinical record revealed: R116 was admitted to the facility on 10/15/22 and was ordered the following medications: 1. Galantamine Hydrobromide 8 mg, give two tablets (tabs) by mouth daily for Alzheimer's Disease. 2. Potassium Chloride 20 MEQ Extended	F 760	A. R116 was assessed by E20 at the time of medication error identification on 4/5/23. There is no adverse effect to R116 related to the deficient practice. NP performed medication review and changed medications to a crushable or liquid state as appropriate for administration 4/6/23. Facility unable to correct due to resident is no longer in the building. E20 was educated regarding medications that cannot be crushed on 4/5/23. B. List of oral meds that should not be crushed was provided to the licensed nursing staff. C. The root cause is determined to be due to the licensed nurse lack of understanding of medications that are crushable. Staff Development/Designee will in-service licensed nurse/new hires/agency staff of medications on the do not crush list. D. Daily random audit by DON/Designee of licensed nursing staff knowledge of non-crushable meds will be conducted x 7 days until 100% compliance is achieved and sustained. Following will be a weekly audit x 4, then monthly x 3 months with a	

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F 760	Continued From page 18 Release, give one tab by mouth daily for nutritional supplementation. 3. Levetiracetam 500 mg, give one tab by mouth twice a day for seizures. 4/5/23 9:00 AM - During a random medication pass, E20 (RN) administered the above meds to R116 after crushing them. 4/5/23 10:30 AM - During an interview, E20 confirmed the medication instructions for Galantamine Hydrobromide, Potassium Chloride Extended Release and Levetiracetam stated the medications should not be crushed. Findings were reviewed with E1 (NHA), E2 (DON) and E3 (Regional Nurse) during the exit conference, beginning at approximately 1:15 PM.	F 760	goal of 100% is achieved and sustained. In an event where compliance is consistently below the goal, the Interdisciplinary Team (IDT) will meet with the QA Committee to review the process and revision will be made to maintain and sustain compliance. Audit findings will be reported to QA committee monthly x 3 months.	
F 790 SS=D	Routine/Emergency Dental Srvcs in SNFs CFR(s): 483.55(a)(1)-(5) §483.55 Dental services. The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(a) Skilled Nursing Facilities A facility- §483.55(a)(1) Must provide or obtain from an outside resource, in accordance with with §483.70(g) of this part, routine and emergency dental services to meet the needs of each resident; §483.55(a)(2) May charge a Medicare resident an additional amount for routine and emergency dental services;	F 790		6/6/23

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F 790	Continued From page 19 §483.55(a)(3) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; §483.55(a)(4) Must if necessary or if requested, assist the resident; (i) In making appointments; and (ii) By arranging for transportation to and from the dental services location; and §483.55(a)(5) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that for one (R98) out of two sampled residents for dental services, the facility failed to assist the resident in obtaining routine dental services. Findings include: A facility policy and procedure titled, "Resident Dental Care", undated, documented: "It is the policy of this facility, in accordance with residents' needs, to assist residents in obtaining routine (to the extent covered under State Plan) and emergency dental care. 1. The dental needs of each resident are identified through the physical assessment and are addressed in each resident's plan of care. 1. Oral/dental status shall be	F 790	A. R98 had a dental appointment scheduled and conducted on 4/6/23. B. Active residents will be reviewed to ensure routine dental care is offered. Residents identified not having offered routine dental care will be scheduled for a dental appointment. C. The root cause was determined to be due to the facility□s lack of process with tracking dental services provided for the residents. NHA/Designee will in-service social	

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F 790	Continued From page 20 documented according to assessment findings. R98's clinical record revealed: 2/1/21 - R98 was admitted to the facility with a diagnosis of Parkinson's Disease (a progressive disorder of the nervous system that affects movement or a disorder of the brain that leads to shaking (tremors) and difficulty in walking, movement and coordination). 4/3/23 10:00 AM - During a random observation and interview R98 had two teeth on his left upper gum that were darkened in color. R98 said that he had a tooth that had broken off in the back of the left lower side of his mouth and two teeth that had broken off on the left upper side. R98 said, "I need to get my teeth checked, the last time I saw a Dentist he told me that I had a few cavities that needed to be filled." 4/5/23 09:03 AM - E1 (NHA) stated, "R98 has not been seen by the Dentist and I don't know why, but he hasn't." 4/5/23 11:48 AM - An interview with E24 (LPN) revealed that all the residents are seen by the Dentist for routine dental services for getting their teeth cleaned." E24 did not know if R98 was seen by the Dentist recently. 4/5/23 12:08 PM - An interview with RP1 (Responsible Party) revealed "The facility told him that they have a Dentist that comes to the facility and R98 would be seen by the facility's Dentist." The facility failed to identify a potential need for dental services by not providing care and services to maintain oral health for a resident admitted to	F 790	services department regarding importance of tracking dental services and scheduling. D. Monthly audit of dental appointments will be conducted by NHA/Designee to ensure residents are scheduled for routine dental services as needed x 3months with a goal of 100% is achieved and sustained. Monthly audit will continue 3months. In an event where compliance is consistently below the goal, the Interdisciplinary Team (IDT) will meet with the QA Committee to review the process and revision will be made to maintain and sustain compliance. Audit findings will be reported to QA committee monthly x 3 months.	

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F 790	Continued From page 21 the facility on 2/1/2021. 4/11/23 Findings were reviewed with E1 (NHA), E2 (DON) and E3 (RN) during the Exit Conference, beginning at 1:15 PM.	F 790		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure that all staff employ hygienic practices, ensure the safe storage of food and beverages, and ensure food storage and preparation equipment is kept clean. Findings include: 4/03/23 8:32 AM - During the initial tour of the Kitchen, the Surveyor observed significant	F 812	A. The walk-in refrigerator was cleaned to ensure no food debris is on the floor and shelves of the walk-in refrigerator on 4/3/23. Food debris under the oven was cleaned, and the support pad under the sanitizer delivery tube above the third compartment was removed on 4/3/23.	6/6/23

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F 812	Continued From page 22 amounts of food crumbs, dried food particles and other small pieces of debris on the floor and shelves of the walk-in refrigerator. 4/03/23 9:25 AM - During a follow-up visit to the Kitchen, the Surveyor observed a foil covered tray with large amounts of food debris on it under an oven, a damaged support pad under the sanitizer delivery tube above the third compartment of the three (3) compartment sink and several areas of cracked and peeling paint adjacent to the three (3) compartment sink and the cooking equipment. 4/03/23 11:10 AM - During a follow-up visit to the Kitchen, the Surveyor observed a staff person enter the Kitchen to assist with serving lunch. The staff member did not have a hair net on. When the staff person was instructed by another staff person to put on a hair net; it was being worn incorrectly allowing large amounts of hair unsecured while plating food. 4/05/23 1:29 PM - E1 (NHA) confirmed all findings. Findings were reviewed during the Exit Conference with E1, E2 (DON), and E3 (Regional Nurse) on 4/11/23 at approximately 1:15 PM.	F 812	Repainted area around the compartment sink and cooking equipment completed on 4/11/23. Dietary staff was educated on the application of hair nets on 4/3/23. B. Kitchen inspection was conducted by Regional Dietary Director. Areas identified that need to be cleaned and items needing repair will be cleaned/repaired as applicable. Dietary staff will be re-educated regarding proper way of wearing hairnets while in the kitchen. Dietary staff will be re-educated on protocols related to overall kitchen cleanliness. C. The root cause was determined to be due to lack of routine cleaning schedule and opening and closing responsibilities of dietary staff. The root cause of staff not wearing hairnet/improper way of wearing hairnet was due to lack of full understanding of the importance of wearing hairnet. Regional Dietary Director/Designee will in-service kitchen staff regarding routine cleaning and routine inspection of areas in the kitchen. The Food Service Director/Designee will educate dietary staff regarding overall	

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	085020	A. BUILDING _____ B. WING _____	C 04/11/2023

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F 812	Continued From page 23	F 812	kitchen cleanliness, proper way of wearing hairnets, cleaning schedule and opening and closing responsibilities. D. Random audits during breakfast, lunch and dinner by Food Service Director/Designee of kitchen cleanliness and wearing of hairnet will be completed daily x 7 days until 100% compliance is achieved and sustained. Following will be a weekly audit x 4, then monthly x 3 months with a goal of 100% is achieved and sustained. In an event where compliance is consistently below the goal, the Interdisciplinary Team (IDT) will meet with the QA Committee to review the process and revision will be made to maintain and sustain compliance. Audit findings will be reported to QA committee monthly x 3 months.	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident	F 842		6/6/23

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F 842	Continued From page 24 that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain-	F 842		

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F 842	Continued From page 25 (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R7) out of five residents reviewed for unnecessary medication administration, the facility failed to properly identify the appropriate indication for which the medication Tamsulosin was being administered. Findings include: 1/3/23 - Admission to the facility with a history of neuromuscular dysfunction of the bladder, unspecified. 4/6/23 untimed - Review of R7's chart revealed that R7 was prescribed Tamsulosin HCl Oral Capsule 0.4 MG, "Give 0.4 mg by mouth at bedtime for Benign Prostate Take 1 capsule (0.4 mg total) by mouth once a day after breakfast." 4/6/23 2:20 PM - During an interview with E19 (LPN), he/she stated that R7 was prescribed Tamsulosin for "benign prostate." The Surveyor said to E19 (LPN), "But this resident is a woman", noting that females do not have a prostate. E19 (LPN) then confirmed benign prostate was the wrong indication for R7 to receive this medication.	F 842	A. R7 has no current order for Tamsulosin. R9□s Tamsulosin□s indication for use was clarified on 4/11/23. E19 was educated on the indication for use for Tamsulosin. B. Active residents with prescribed Tamsulosin will be reviewed to ensure indication for use is appropriate. C. The root cause was determined to be the admitting licensed nurse inadvertently selecting an inaccurate diagnosis coding not appropriate for the resident. Staff Development/Designee will educate licensed nurses/new hires and agency regarding appropriate indication for use of Tamsulosin order. During the new admission/readmission medication chart review, indication for use will be reviewed for appropriateness. D. Daily audit by DON/Designee of new	

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F 842	Continued From page 26 4/11/2023 approximately 1:30 PM - Findings were reviewed at the Exit Conference with E1 (NHA), E2 (DON) and E3 (Regional Nurse).	F 842	admissions/readmissions and new medication orders of residents prescribed with Tamsulosin will be reviewed for appropriate indication x 7 days until 100% compliance is achieved and sustained. Following will be a weekly audit x 4, then monthly x 3 months with a goal of 100% is achieved and sustained. In an event where compliance is consistently below the goal, the Interdisciplinary Team (IDT) will meet with the QA Committee to review the process and revision will be made to maintain and sustain compliance. Audit findings will be reported to QA committee monthly x 3 months.	
F 887 SS=D	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination	F 887		6/6/23

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F 887	Continued From page 27 requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses; (v) The resident, resident representative, or staff member has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident; or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to provide one	F 887	A. Unable to correct the action. 3 consent forms for COVID-19 vaccine for	

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F 887	Continued From page 28 (R98) out five sampled residents for immunizations, an informed consent for four administered doses of the COVID-19 vaccine. Findings include: A facility policy and procedure titled, "Infection Prevention and Control Program", revised 10/2022, documented: The facility has established and maintains an infection prevention and control program designed to provide safe, sanitary, and comfortable environment and to help to prevent the development and transmission of communicable diseases and infection. 8. COVID-19 Immunization: c. Education about the vaccine, risks, benefits, and potential side effects will be given to residents or resident representatives and staff prior to offering the vaccine. R98's clinical record revealed: - 6/30/21 Dose 1 SARS-COV-2 (COVID-19) Moderna US Inc. 053C21A; - 7/28/21 Dose 2 SARS-COV-2 (COVID-19) Moderna US Inc. 006D21A; - 3/15/22 Moderna Booster 033K21; - 8/16/22 Pfizer Booster. 4/10/23 1:30 PM - During a review of R98's immunization record, E24 (LPN) confirmed the dates that COVID-19 vaccines and boosters were given to R98 and that the record of R98's informed consent was dated 12/1/22 (after the vaccines and boosters) and signed by E24. 4/11/23 Findings were reviewed with E1 (NHA), E2 (DON) and E3 (RN) during the Exit Conference, beginning at 1:15 PM.	F 887	R98 were acquired prior to vaccine administration. Last booster consent form was not located. No adverse effects related to the alleged deficient practice. B. Active residents COVID-19 vaccine consent forms will be reviewed and made available in the medical record. C. The root cause was determined to be due to not having a clear system in place for COVID-19 consent form documents. Staff Development/Designee will educate licensed staff/new hires and agency staff to ensure consents for COVID-19 vaccination is available prior to administration of vaccines. Consent forms will be scanned into the electronic Medical Record prior to pharmacy notification. D. Weekly audit by ADON/Designee of residents with pending COVID-19 vaccination will be reviewed to ensure that consents were obtained prior to vaccine administration x 2 weeks until 100% compliance is achieved and sustained , then monthly x 3 2 months with a goal of 100% is achieved and sustained. In an event where compliance is consistently below the goal, the Interdisciplinary Team (IDT) will meet with the QA Committee to review the process and revision will be made to maintain and sustain compliance. Audit findings will be reported to QA committee monthly x 3 months.	