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: Shipley Living
January 8, 2024

DATE SURVEY COMPLETED:

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 complaint survey was conducted at this facility starting on December 13, 2023 and completed on January 8, 2024. The facility census the first day of the survey was 72 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 01/08/2024: F622, F623, F625, F637, F644, F660, F695, F697, F745.		

Provider's Signature Eric Baida Title Executive Director Date 1-25-2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085031	A. BUILDING _____ B. WING _____	C 01/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHIPLEY LIVING	2723 SHIPLEY ROAD WILMINGTON, DE 19810

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F 000	INITIAL COMMENTS	F 000		

An unannounced complaint survey was conducted at this facility starting on December 13, 2023 and completed on January 8, 2024. The facility census the first day of the survey was 72 residents.

Afib - atrial fibrillation; a heart condition that makes the heartbeat irregular and fast. It places a person at risk for clots, stroke, heart failure and other complications;
ALF - Assisted Living Facility;
BIMS - Basic Inventory of mental Status; a structured assessment tool aimed at evaluating cognition in the elderly. BIMS score of 0-7 is reflective of severe cognition deficit, 8-12 reflects a moderate cognition deficit and 13 to 15 is reflective of normal cognition;
COPD - chronic obstructive pulmonary disease;
CT - computed tomography scan;
D/C - discharge;
DO - doctor of osteopathy;
ED - Emergency department;
EMAR - electronic medical record;
GDR - gradual dose reduction;
Hoyer lift - a patient lift utilized to transfer people with limited mobility. Typically requires two people to operate the lift;
HHA - home health aide;
IDT - interdisciplinary team;
LTC- long-term care;
MA - medical assistant;
MAR - Medication Administration Record;
MD - medical doctor;
MDS - Minimum Data Set; a standardized assessment tool that measures health status in nursing home residents;
Mg - milligrams;

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

Electronically Signed | 01/22/2024

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F 000	Continued From page 1 Nasal cannula - a tube that delivers supplemental oxygen to a resident. The tube is placed approximately one-half inch into the resident ' s nose and is held in place by an elastic band around the resident ' s head OT - Occupational Therapy; OTR - Registered Occupational Therapy; Pain scale - a technique used in health care to quantify pain level. The numbers range from 0 (no pain) to 10 (the worst pain experienced); PASARR - Preadmission Screening and Resident Review; a federal- and state-required process to identify serious mental illness and/or intellectual or developmental disabilities; POA - power of attorney; PT - Physical Therapy; RN - registered nurse; SOB - shortness of breath; ST - Speech Therapy; TAR - Treatment Administration Record.	F 000		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;	F 622		2/5/24

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F 622	Continued From page 2 (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)	F 622		

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F 622	Continued From page 3 (i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, it was determined that for one (R6) out of three residents reviewed for discharge, the facility failed to allow R6, who still required the nursing services provided by the facility, to remain in the facility and to assist R6 with the Medicaid coverage application. Findings include:	F 622	Corrective action: " Corrective actions have been ensured by the Director of Nursing. R6 is no longer a resident in the facility. The Director of Nursing/Designee has completed nursing staff education to prevent a recurrence of this concern.	

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F 622	Continued From page 4 Review of R6's clinical record revealed: 11/3/23 - R6 was admitted to the facility with diagnoses including but not limited to morbid obesity, right elbow bursitis, weakness and major depressive disorder. 12/1/23 - E7 (MD) entered an order in R6's EMAR that stated, "Discharge Home: D/C (discharge) resident from skilled services PT/ OT/ST to home/ ALF (assisted living facility) on 12/2/23 with Home Health services, RN eval, PT, OT HHA (home health aide)." 12/2/23 10:59 AM - E8 (RN) electronically signed R6's Transition of Care and Discharge Summary. R6's Discharge Summary stated, " ...Bowel and Bladder- Bowel continence- occasionally incontinent. Urinary incontinence- occasionally incontinent ...Nursing Summary of Stay- ...Resident is continent of bowel and bladder with use of bedpan. Resident is a Hoyer transfer ...". E9 (OTR) documented in R6's Transition of care and discharge Summary," ...Therapy Assistance recommended- Transfers- substantial maximal assistance ...Bathroom activity- substantial maximal assistance ...Personal hygiene- substantial maximal assistance ...Ability to move from one location to another- dependent ...Bathing- substantial maximal assistance. Therapy summary of stay- ...Patient with limited out of bed activity. Recommend 24 hour care at the time of discharge." 12/2/23 11:00 AM - R6 discharged home via stretcher in an ambulance. R6's discharge destination was an apartment in an independent living community, where R6 lived alone.	F 622	Identification of Other Residents: " All residents have the potential to be affected. In order to prevent other residents from being affected, all nursing staff and members of the IDT have been educated on the Discharge Process. A 100% audit was completed on all current residents to determine the need to start the Medicaid application process. System Changes: " The root cause of this concern was failure of the IDT to communicate the residents need to stay in the community and start the Medicaid application process. The facility system for monitoring discharge status has been updated. All pending discharges will be discussed in the daily clinical review meeting as well as the Utilization Review meeting. All members of the IDT team will be notified via email of any residents with a need to apply for Medicaid assistance. Success Evaluation: " A 100% audit of all current Med A/Managed care residents was completed to identify the need for assistance with the Medicaid application process. Subsequent audits of 25% of upcoming discharges will have a goal of 100% compliance; Audits of 25% of upcoming discharges will be completed weekly until 100% compliance is achieved for 3 consecutive evaluations, then every other week until 100%	

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F 622	Continued From page 5 1/3/24 2:10 PM - During an interview with E2 (DON) and E4 (acting ADON), E4 stated, "We should have done AMA if we knew she was leaving. We thought she was staying and filling out Medicaid paperwork." 1/3/24 2:42 PM - During an interview, E10 (Business Office Manager) stated that she spoke with F1 (R6's son) on the phone on Wed 11/29/23 at 2:30 PM. E10 stated, "I sent the Medicaid application and an informational packet via email on 11/29 at 2:58 PM. The son [F1] was going to call me with a time that he [F1] would come in and fill out the Medicaid application. I re-sent the email on Sunday 12/3/23 because the email bounced back due to the wrong email address." E10 stated that discharging AMA was never discussed as "I [E10] thought she [R6] was staying and completing the Medicaid application. Sometime after 4 pm Friday 12/1 and Saturday 12/2, she [R6] decided to discharge and left the facility." E10 also stated, "Looking at her data, it is likely that she [R6] would have qualified for Medicaid coverage." 1/3/24 3:23 PM- During an interview, E4 (acting ADON) stated, "We were all operating under the idea that she [R6] was staying and filling out the Medicaid application. Then the following week (after R6 had discharged on 12/2/23), we [E4, E2] saw the social work note dated 11/30/23 2:38 PM stating 'she [R6] is scheduled to discharge on Saturday 12/2/23 ... set up transportation through [transport company] to get her a ride home'. This information (that transportation home was set up for R6 on Saturday 12/2/23) was not communicated to us [E2, E4]."	F 622	compliance is achieved for 3 consecutive evaluations, and then monthly until 100% compliance is achieved for 3 consecutive evaluations. Additional audits will be completed as needed based upon the level of compliance. The results of the audits will be reviewed by the Quality Assurance Team.	

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F 622	Continued From page 6 1/8/24 12:30 PM - Findings were reviewed with E1 (NHA), E2 (ADON), E3 (Clinical specialist), E4 (acting ADON) and E14 (DON) at the exit conference.	F 622		
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 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;	F 623		2/5/24

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F 623	Continued From page 7 (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: (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	F 623		

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F 623	Continued From page 8 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. §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 (R15) out of three residents reviewed for hospitalization, the facility failed to notify the LTC Ombudsman of R15's transfer and admission to the hospital on 10/23/23. Findings include: 6/28/23 - R15 was admitted to the facility with diagnoses including but not limited to stroke and diabetes. 9/29/23 - A quarterly Minimum Data Set (MDS) assessment documented R15's Basic Inventory of Mental Status (BIMS) as 15, which was reflective of normal cognition.	F 623	Corrective Action: · Corrective actions have been ensured by the Director of Nursing. Notice of the transfer for R15 has since been provided to the Ombudsman. Identification of Other Residents: · All Residents have the potential to be affected. To prevent other residents from being affected, all nursing and social services staff members will be trained in the requirement to provide notice of transfer or discharge to the Ombudsman.	

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F 623	Continued From page 9 10/23/23 - R15 admitted to [hospital] with osteomyelitis and underwent a right fifth toe amputation. 1/5/24 10:15 AM - During an interview, E4 (ADON) stated that she looked at the month of October Ombudsman notification sheet and R4 was not on the list. 1/8/24 12:30 PM - Findings were reviewed with E1 (NHA), E2 (ADON), E3 (Clinical specialist), E4 (acting ADON) and E14 (DON) at the exit conference.	F 623	A 100% audit of all discharges and transfers in the last 30 days has been completed to ensure Ombudsman notification. An updated list of all transfers and discharges in the last 30 days has been provided to the Ombudsman and no remaining concerns regarding Ombudsman notification are noted. System Changes: · The Root Cause of the concern was that the staff (social worker and nursing) did not have the knowledge to complete the notification of the Ombudsman. The facility policy "Transfer or Discharge Notice" was reviewed and found to meet professional standards. The Social Service Director/designee will be responsible for notifying the Ombudsman of all transfers/discharges. The facility system for daily clinical review meetings has been updated to include a review of all transfers and discharges to ensure that all residents are appropriately listed on the Transfer/Discharge Form and that it has been provided to the Ombudsman. The Director of Nursing or Designee will complete education for all nursing and social services staff regarding the requirement to provide notice of transfer or discharge to the Ombudsman. The nursing management team will provide oversight to ensure ongoing compliance. Success Evaluation: · A 100% audit of all discharges and transfers in the last 30 days has been	

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F 623	Continued From page 10	F 623	completed to ensure the accuracy of the Ombudsman notification. Subsequent audits of all discharges in the previous 7 days will be completed by the Director of Nursing or Designee to ensure that all residents who have been transferred/discharged are present on the Ombudsman notification form and sent to the Ombudsman monthly; Audits will have a goal of 100% compliance; Audits will be completed weekly until 100% compliance is achieved for 3 consecutive evaluations, then every other week until 100% compliance is achieved for 3 consecutive evaluations, and then monthly until 100% compliance is achieved for 3 consecutive evaluations. Additional audits will be completed as needed based upon the level of compliance. The results of the audits will be reviewed by the Quality Assurance Team.	
F 625 SS=E	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;	F 625		2/5/24

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F 625	Continued From page 11 (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, it was determined that that for three (R1, R4 & R15) out of three residents reviewed for hospitalization, the facility failed to issue bed- hold notice upon their hospitalizations. Findings include: 1-Review of R1's clinical record revealed: 5/29/23 - R1 was admitted to the facility with diagnoses including, but not limited to, diabetes, heart failure and right foot ulcer. 6/12/23 - An admission Minimum Data Set (MDS) assessment documented R1's BIMS score as 12, which was reflective of moderate cognitive deficit. 6/29/23 11:15 AM - E20 (LPN) documented in a Transfer Out to Hospital note, "Resident is being sent to hospital per family request for right foot wound. Resident is alert and oriented x (times) 3 at time of transfer." The facility was not able to produce evidence of	F 625	Corrective Action: " Corrective actions have been ensured by the Director of Nursing. R1 and R4 are no longer residents in the facility. The Director of Nursing has completed nursing staff training to prevent a recurrence of this concern. Identification of Other Residents: " All Residents have the potential to be affected. To prevent other residents from being affected, all nursing and social services staff members will be trained on the requirement to provide notice of bed hold policy and return to the resident/POA on discharge. A 100% audit of all discharges and transfers in the last 30 days has been completed to ensure Resident/POA notification of the Bed Hold policy. No new concerns regarding Resident/POA notification of the Bed Hold	

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F 625	Continued From page 12 the written bed-hold policy that was/should have been given to R1 or her family member at the time of transfer to the hospital. 2- Review of R4's clinical record revealed: 10/4/23 - R4 was admitted to the facility with diagnoses including, but not limited to, heart failure, systemic lupus and seizures. 10/8/23 - The 5 Day Medicare MDS assessment documented R4's BIMS score as 9, which was reflective of moderate cognitive deficit. 12/12/23 11:30 AM - E20 (agency RN) documented in an order note, "Resident with increased SOB (shortness of breath), productive cough and fever 102.1 F. Seen by the provider [E7], order to transfer to hospital given. POA [F3] was made aware. Left with 911 for [hospital] ED (emergency department) with appropriate paperwork at 11:30 AM." The facility was not able to produce evidence of the written bed-hold policy that was/should have been given to F3 (R4's daughter) at the time of transfer to the hospital. 3- Review of R15's clinical record revealed: 6/28/23 - R15 was admitted to the facility with diagnoses including but not limited to stroke and diabetes. 9/29/23 - A quarterly MDS assessment documented R15's BIMS score as 15, which was reflective of normal cognition. 10/23/23 - R15 admitted to [hospital] with	F 625	policy are noted from this audit. System Changes: " The Root Cause of the concern was the failure to provide a bed-hold notice upon R1, R4, and R15□s hospitalization. The facility policy Bed-Holds and Returns was reviewed and found to meet professional standards. The facility system for daily clinical review meetings has been updated to include a review of all transfers and discharges to ensure that the Resident/POA has been notified of the Bed Hold policy. The Director of Nursing or Designee will complete education for all nursing and social services staff regarding the requirement to provide Resident/POA notification of the Bed Hold policy. The nursing management team will provide oversight to ensure ongoing compliance. Success Evaluation: " A 100% audit of all discharges and transfers in the last 30 days has been completed to ensure Resident/POA notification of the Bed Hold policy. Subsequent audits of all discharges in the previous 7 days will be completed by the Director of Nursing or Designee to ensure that Resident/POA was notified of the Bed Hold policy; Audits will have a goal of 100% compliance; Audits will be completed weekly until 100% compliance is achieved for 3 consecutive evaluations, then every other week until 100% compliance is achieved for 3 consecutive evaluations, and then monthly until 100%	

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F 625	Continued From page 13 osteomyelitis and underwent a right fifth toe amputation. The facility was not able to produce evidence of the written bed-hold policy that was/should have been given to R15 at the time of transfer to the hospital. 1/8/24 11:05 AM - During an interview, E3 (Clinical Specialist) stated, "We don't have those forms (bed hold upon transfer) for those three residents (R1, R4 and R15). We were without a social worker for months." 1/8/24 12:30 PM - Findings were reviewed with E1 (NHA), E2 (ADON), E3 (Clinical specialist), E4 (acting ADON) and E14 (DON) at the exit conference.	F 625	compliance is achieved for 3 consecutive evaluations. Additional audits will be completed as needed based upon the level of compliance. The results of the audits will be reviewed by the Quality Assurance Team.	
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R10) out of four	F 637	Corrective Action:	2/5/24

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F 637	Continued From page 14 residents reviewed for Hospice care, the facility failed to complete an MDS assessment documenting R10's significant change regarding his hospice admission. Findings include: 6/15/23 - R10 was admitted to the facility with diagnoses including, but were not limited to, stroke, seizures and congestive heart failure (CHF). 12/8/23 - R10 was admitted to hospice services at the facility. 1/5/24 - The Surveyor observed that R10's significant change Minimum Data Set (MDS) assessment was noted as "in progress". This was twenty-eight (28) days after his admission to hospice and fourteen (14) days after R10's deadline for completion of the significant change MDS assessment. 1/5/24 1:35 PM - During an interview, E3 (Clinical Specialist) confirmed that R10's significant change MDS assessment's status was still "in progress". 1/8/24 9:20 AM - E22 (Admission coordinator) delivered a copy of R10's completed significant change MDS (dated 12/14/23) to this Surveyor. 1/8/24 12:30 PM - Findings were reviewed with E1 (NHA), E2 (ADON), E3 (Clinical Specialist), E4 (acting ADON) and E14 (DON) at the exit conference	F 637	" Corrective actions have been ensured by the Director of Nursing. The significant change assessment for R10 was reviewed by the Interdisciplinary Team (IDT), including the attending physician, hospice staff, nursing management, MDSC, and social services; this review found the resident assessment to be up to date and accurate. Identification of Other Residents: " All Residents have the potential to be affected. Other residents will be protected by ensuring that all residents who experience a significant change will be identified and have a significant change assessment completed within 14 days. A 100% audit of all residents has been completed to ensure that all significant changes have been identified and the required significant change MDS assessments have been completed. No new concerns about resident assessments were identified from this audit. System Changes: " The Root Cause of the concern was failure to complete a Significant Change MDS on R10 in accordance with the RAI Manual. The facility policy Resident Assessments was reviewed and found to meet professional standards. The Director of Nursing or Designee will complete education for all nursing including MDSC and social services staff on the requirements for significant change	

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F 637	Continued From page 15	F 637	assessments. The nursing management team will provide oversight to ensure ongoing compliance. Success Evaluation: " An initial 100% audit of all residents will be completed by the Director of Nursing or Designee to identify any needed significant change assessments; Audits will have a goal of 100% compliance; Audits will be completed weekly until 100% compliance is achieved for 3 consecutive evaluations, then every other week until 100% compliance is achieved for 3 consecutive evaluations, and then monthly until 100% compliance is achieved for 3 consecutive evaluations. Additional audits will be completed as needed based upon the level of compliance. The results of the audits will be reviewed by the Quality Assurance Team.	
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of	F 644		2/5/24

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F 644	Continued From page 16 care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, it was determined that for one (R6) out of three residents reviewed for Preadmission Screening and Resident Review (PASARR) coordination, the facility failed to be compliant with R6's PASARR mandated specialized services of a one-time psychiatric medication management evaluation by a psychiatrist/psychiatric nurse practitioner within 30 days of admission. Findings include: Review of R6's clinical record revealed: 11/1/23 - R6's PASARR determination at the hospital documented R6's medical history as including two suicide attempts by overdosing on her medications on 9/24/23 and 9/25/23 with hospitalization on 9/26/23, hospitalization 10/10/23- 10/27/23 for kidney stones, and rehospitalization on 10/28/23 after one day at home due to a fall. PASARR determination explanation stated, " ...You have a Level II PASARR condition of Major Depressive Disorder, recurrent, severe, without psychosis which has recently led to functional impact and need for ongoing treatment support. If you are admitted to a Medicaid certified nursing facility ...you will need to be provided the following specialized services: Psychiatric Provider Evaluation within 30 days of admission. A	F 644	Corrective action: " Corrective actions have been ensured by the Director of Nursing. R6 is no longer a resident in the facility. The Director of Nursing/Designee has completed staff education to prevent a recurrence of this concern, including the Social Services Director, the MDS Coordinator, the Admissions Director as well as the IDT team. Identification of Other Residents: " All residents have the potential to be affected. In order to prevent other residents from being affected, all staff members involved in the PASARR process have been educated. A 100% audit was completed on all current residents□ PASARR levels. No other residents currently in the community were identified as having a Level 2 PASARR. System Changes: " The root cause of this concern was failure of the IDT to identify a resident with a Level 2 PASARR and failure to implement the PASARR□s recommendations. PASARR review will be conducted starting with the referral process. The Admissions Director will	

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F 644	Continued From page 17 one-time psychiatric medication management evaluation by a psychiatrist/psychiatrist nurse practitioner/medical doctor (to evaluate response and effectiveness of psychotropic medications ...) ...To be compliant, this service must be delivered within 30 days of the resident admitting or re-admitting from a hospitalization to the nursing facility." 11/3/23 - R6 was admitted to the facility with diagnoses including, but were not limited to, morbid obesity, right elbow bursitis, weakness and major depressive disorder. 11/3/23 - E7 (DO) ordered, "May have psych consult and treatment" in R6's EMAR (electronic medical record). 11/5/23 - E7 (DO) gave a verbal order for, "bupropion HCL ER (XL) 150 mg (milligrams)- give one tablet by mouth in the morning related to depression." 11/21/23 - E7 (DO) entered an order in R6's EMAR for, "bupropion HCL 75 mg- give one tablet by mouth in the morning for depression." 12/1/23 - E7 (DO) entered an order in R6's EMAR that stated, "Discharge Home: D/C (discontinue) resident from skilled services PT/ OT/ST to home/ ALF (assisted living facility) on 12/2/23 with Home Health services, RN eval, PT, OT, HHA (home health aide)." 12/2/23 11:00 AM - R6 was discharged home via stretcher by a [transport company] ambulance. 1/4/23 11:35 AM- During an interview, E4 (acting ADON) stated, "No, I did not find any psych	F 644	obtain a copy of the resident□s PASARR prior to admission. Any level 2 assessments will be identified, and the IDT will be notified. In addition, all new admissions will be reviewed during the daily clinical meeting. PASARR levels on all new admissions will be discussed and any recommendations will be implemented. Success Evaluation: " A 100% audit was completed on all current residents□ PASARR levels. Subsequent audits will have a goal of 100% compliance; Audits will be completed weekly until 100% compliance is achieved for 3 consecutive evaluations, then every other week until 100% compliance is achieved for 3 consecutive evaluations, and then monthly until 100% compliance is achieved for 3 consecutive evaluations. Additional audits will be completed as needed based upon the level of compliance. The results of the audits will be reviewed by the Quality Assurance Team.	

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F 644	Continued From page 18 (psychiatry) notes for R6. I called the Psych NP (E6) to see if she has any. We [the facility] did have GDR (gradual dose reduction) meeting on 12/13/23 but she (R6) was gone (discharged) by then." 1/5/23 10:35 AM - During an interview, E4 (acting ADON) stated that if a resident is determined to need a psych (psychiatry) consult, their name and room number is written in a E5's (psychiatrist) book at the nurse's station. When E5 comes to the facility, he [E5] checks the book and sees the residents listed. E4 (acting ADON) reported there was no record of R6's name in the Psych book at the nurses' station. 1/5/23 10:54 AM - Electronic message (text) from E5 (Psychiatrist) stated, "I tried to call you back. I don't see patients but my NP [E6] goes there. When I went to do GDR, patient [R6] was already discharged. So I am sorry I don't know the patients (sic)." 1/5/23 4:43 PM - During a telephone interview, E6 (E5's Psych NP) stated, "I checked my billing records. I did not see R6 listed so I did not see her." Both E5 (Psychiatrist) and E6 (Psych NP) confirmed that they did not have any encounters with R6 nor evaluated her medications' effectiveness as required by R6's PASARR. 1/8/24 12:30 PM - Findings were reviewed with E1 (NHA), E2 (ADON), E3 (Clinical specialist), E4 (acting ADON) and E14 (DON) at the exit conference.	F 644		
F 660 SS=J	Discharge Planning Process	F 660		2/5/24

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F 660	Continued From page 19 CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning	F 660		

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F 660	Continued From page 20 to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, it was determined that for one (R6) out of three	F 660	Corrective Action:	

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F 660	Continued From page 21 residents reviewed for discharge, the facility failed to develop and implement an effective discharge planning process. The facility failed to determine and document the feasibility of R6 returning to live in the community independently. The facility failed to ensure R6's health and safety needs were able to be met at her discharge destination. The facility failed to ensure R6 had the ability to fill her medication prescriptions. The facility failed to ensure that R6's discharge prescriptions for PT/OT, home health aide and nursing were referred to an accepting agency and the first visit by the agency was scheduled for R6. These failures placed R6 in Immediate Jeopardy (IJ). An IJ was called on 1/5/24 at 2:49 PM. The IJ was abated on 1/8/23 at 12:46 PM. Findings include: The facility's policy stated, "Discharge Summary and Plan: Policy Statement- When a resident's discharge is anticipated, a discharge summary and post-discharge plan will be developed to assist the resident to adjust to his/her new living environment ...If a resident indicates interest in returning to the community, he or she will be referred to local agencies and support services that can assist in accommodating the resident's post discharge preferences ...A member of the IDT (interdisciplinary team) will review the final post-discharge plan with the resident and family at least twenty-four (24) hours before the discharge is to take place." 2001 MEDPASS (Revised December 2016). Cross refer F622, F644 and F745 Review of R6's clinical record revealed: 11/3/23 - R6 was admitted to the facility with diagnoses including, but were not limited to	F 660	" Corrective actions have been ensured by the Administrator and Director of Nursing. R6 is no longer a resident in the facility. The facility Licensed Nurses, Therapy Staff, and Social Services Staff have been educated on the Discharge Planning Process to ensure safe Resident Discharges and the arrangement of care services upon discharge. Identification of Other Residents: " All Residents have the potential to be affected. Other residents will be identified by completing an audit of the Discharge Planning Process for all recently discharged residents (in the last 30 days) and all short-term residents. A 100% audit of all recently discharged residents in the last 30 Days have been audited to ensure that appropriate discharge planning was completed and that referrals for needed care services were completed to ensure that the resident has received appropriate care services post-discharge. A 100% audit of all current short-term residents has been audited to ensure that a Discharge Assessment has been completed and that Discharge planning is current for the Residents in their course of stay. No new concerns about physician notification of changes were identified from this audit. System Changes: " The Root Cause of the concern was the failure to ensure appropriate Discharge Planning and the coordination	

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F 660	Continued From page 22 morbid obesity, right elbow bursitis, weakness, COPD (chronic obstructive pulmonary disease) and major depressive disorder. 11/30/23 2:38 PM - E11 (LSW) documented in a Social Services Note in R6's EMAR, " ...Resident (R6) was requesting to speak to SW (social work) ...I introduced myself and stated who I was as this was my first time meeting the resident. Resident stated that she needed my help with discharge plans because her managed care plan as (sic) issued her a discharge notice and she is scheduled for discharge on Saturday, 12/2/23. Resident asked if I could order her a bariatric wheelchair and set up transportation through [transport company] to get her a ride home. SW asked her what time she wanted to discharge, and she stated 11 AM would be ideal. Resident did ask how much the daily rate was to stay privately. SW (social worker) informed her the daily rate was $367 a day and resident stated she does not have the money and she will choose to go home and was in agreement with discharging ...A call was placed to resident's son [F1] to inform him of his mother's discharge. F1 stated he understood the process and would go see the resident at home over the weekend to help her fill out the LTC (long term care) Medicaid application. The son never stated any additional information in regard to money, resident staying paying privately or refusing to accept the fact that the resident was discharging." 12/1/23 - E7 (MD) entered an order in R6's EMAR that stated, "Discharge Home: D/C (discharge) resident from skilled services PT/OT/ST to home/ALF (assisted living facility) on 12/2/23 with Home Health services, RN eval (evaluation), PT, OT HHA (home health aide)."	F 660	of care services post-discharge. The facility system for Discharge Planning has been updated to include a review and verification of the current Discharge Planning for all current short-term residents. The Facility has initiated a Discharge Planning Process Checklist that will be completed for all Residents for the Discharge Planning Process. The Discharge Assessment process has been updated to ensure that moving forward Discharge Planning begins the Day of Admission & Discharge Plan is reviewed with Admission Review. Discharge assessment is completed upon admission within 72 hours, including a PASSR review. Discharge Summary will be opened and initiated in the EMR upon admission. The Process for Interdisciplinary Team (IDT) Coordination and Discharge Planning with the Resident/Family has been updated to ensure that all current short-stay Residents will have an IDT Review of their Discharge Plan and any residents with a planned discharge in the next 14 days will have a Resident/Family Discharge planning meeting scheduled. Moving forward, all Residents will have a Discharge Planning Meeting with the IDT and Resident/Family prior to discharge to ensure appropriate Discharge Planning and the coordination of care services post-discharge. The policy for IDT Discharge Review has been updated to ensure that the IDT will review the Discharge Process Planning Checklist for completion prior to resident discharge to ensure that the Discharge Planning	

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F 660	Continued From page 23 R6's discharge destination was an apartment in an independent living community, where R6 lived alone. 12/2/23 10:59 AM - E8 (RN) electronically signed R6's Transition of Care and Discharge Summary. R6's Discharge Summary documented, " ...Skin review ...open area to LLQ (left lower quadrant) [abdomen]. Dressing completed this am ... Skin issue type- incontinent associated dermatitis. Bowel and Bladder- Bowel continence- occasionally incontinent. Urinary incontinence- occasionally incontinent ...Nursing Summary of Stay- ...Resident is continent of bowel and bladder with use of bedpan. Resident is a Hoyer transfer ..." E9 (OTR) documented in R6's Transition of care and discharge Summary," ...Therapy Assistance recommended- Transfers- substantial maximal assistance ...Bathroom activity- substantial maximal assistance ...Personal hygiene- substantial maximal assistance ... Walking- dependent ...Ability to move from one location to another- dependent ...Bathing- substantial maximal assistance. Therapy summary of stay- ...Patient with limited out of bed activity. Recommend 24 hour care at the time of discharge." The facility was unable to provide evidence that R6 was capable of transferring herself from the bed to the chair or to the commode or that R6 was capable of performing personal hygiene after toileting at the time of discharge. 12/2/23 10:59 AM - R6's Discharge Summary did not include any information regarding the	F 660	Process was completed appropriately. The Discharge Planning Process has been updated to include Post-Discharge Wellness Check-Ins; the facility will schedule a follow-up wellness check-in call with the resident/family within 5 days of discharge to identify any challenges post discharge and changes in condition that require a readmission to the SNF. The facility policy Discharge Summary and Plan was reviewed and found to meet professional standards. The Director of Nursing or Designee will complete education for all licensed nurses, therapy staff, and social services staff regarding the requirements for the discharge planning process. The administrator and the nursing management team will provide oversight to ensure ongoing compliance. Success Evaluation: " A Discharge Planning audit will be completed for all short-term care residents to ensure that a Discharge Assessment has been completed and that Discharge planning is current for the Resident in their course of stay will be completed by the Director of Nursing or Designee; Audits will have a goal of 100% compliance; Audits will be completed weekly until 100% compliance is achieved for 3 consecutive evaluations, then every other week until 100% compliance is achieved for 3 consecutive evaluations, and then monthly until 100% compliance is achieved for 3 consecutive evaluations. Additional audits will be completed as	

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F 660	Continued From page 24 transition of R6's care to a provider in the community. In fact, the Discharge summary read, "Follow up with primary care physician: _____." There was no information provided regarding R6's follow up care with a primary care physician. 12/2/23 11:00 AM - R6 was discharged home via stretcher in a [transport company] ambulance. R6 was given a paper prescription for community services that stated, "PT, OT, RN and HHA (home health aide) 3X (times)/wk (week) X 1 month." The facility could not provide evidence that the prescription referrals for outpatient physical therapy (PT), occupational therapy (OT), and registered nurse and home health aide visits from a home health agency had been sent to and accepted by a home health agency. Nor could the facility provide evidence that the first visit for each outpatient service was set up and that information was communicated to R6. R6 was also given paper prescriptions for the eleven medications that she was continue at home. These medications included: Norvasc (blood pressure medication) 10 mg daily, metoprolol (blood pressure medication) 25 mg twice a day, Eliquis (blood thinner for Afib) 5 mg twice a day, Flovent inhaler 100 mcg inhaled twice a day for COPD, lisinopril (blood pressure medication) 30 mg daily, Wellbutrin (depression medication) XL 150 mg daily and Wellbutrin (depression medication) XL 75 mg daily. The facility could not provide any documentation	F 660	needed based upon the level of compliance. The results of the audits will be reviewed by the Quality Assurance Team. A post-discharge review audit will be completed for all newly discharged residents to ensure that the resident has received appropriate care services post-discharge. An initial 100% audit of all discharges in the last 30 days has been completed to ensure that the resident has received appropriate care services post-discharge; additional audits will be completed by the Director of Nursing or Designee; Audits will have a goal of 100% compliance; Audits will be completed weekly until 100% compliance is achieved for 3 consecutive evaluations, then every other week until 100% compliance is achieved for 3 consecutive evaluations, and then monthly until 100% compliance is achieved for 3 consecutive evaluations. Additional audits will be completed as needed based upon the level of compliance. The results of the audits will be reviewed by the Quality Assurance Team.	

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F 660	Continued From page 25 that the medication prescriptions were called into a pharmacy or that arrangements were in place for R6 to fill the prescriptions and obtain her medications. From 12/2/23 (Saturday) at 11 AM until 12/4/23 (Monday) at approximately 7 AM, R6 was alone in her apartment without healthcare services. 12/4/23 7:20 AM - E12 (Emergency Department MD) documented in the ED (Emergency Department) Physician Record, " ... History of Present Illness ...Says she [R6] lives at home, has no assistance at this time ...They [the facility] reportedly were going to work on home health care but she (R6) said there (sic) been none there (sic). She [R6] is unable to ambulate at home, is incontinent of urine at baseline and has been unable to care for herself ...Assessment & Plan: ... She [R6] comes with no real new complaints ...Her physical exam is unremarkable ...". 12/7/23 1:51 PM - E13 (ED DO) documented in ED Physician Record Addendum, " ... Nurse manager has been working with several hospital administrators and case management to help facilitate disposition as pt (patient) has been here in the ED for over 3 days ... was able to secure a bed at a facility (in New Jersey), specifics are still in process." 12/8/23 3:16 PM - R6 was discharged from the hospital Emergency Department and transferred to a facility in New Jersey. R6 spent four days in the hospital Emergency Department while awaiting placement in long term care facility.	F 660		

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F 660	Continued From page 26 1/3/23 1:13 PM - During an interview, E9 (OTR) stated, " ...therapy recommended a hoyer lift with 24 hours care. Business office manager [E10] went over the Medicaid application process. So going into that weekend, I [E9] thought she [R6] was staying. I was there when she signed the NOMNC (notification of medical non-coverage) and the SNF ABN. I thought she was staying. The family said they would be in to fill out the Medicaid paperwork. Not sure what happened - you would need to ask the Business office". With regard to R6's therapy sessions, "she [R6] got out to the wheelchair using a hoyer lift a couple of times. She [R6] had some straight out refusals (to get out of bed for therapy), some 'can we do stuff in bed?' Despite education about trying to get to a level of function where she [R6] could go home and be safe, she [R6] was minimal at participating." When R6 was asked about how she planned to function at home alone, E9 stated, "she [R6] said "I can't go home like this. I'll figure it out." E9 stated that "she [R6] requested that therapy order a bariatric wheelchair but could not order a hoyer as someone has to be there on delivery to get training and R6 lived alone." When asked if AMA (against medical advice) ever came up, E9 stated, "not that I remember." 1/4/24 10:26 AM - During an interview, E11 (Social Worker) stated, "First time I met her [R6] was on 11/30/23 (Thursday), she [R6] said I need you [E11] to arrange transport with [transport company] at 11 am on Saturday (12/2/23) and a bariatric wheelchair. E9 in Therapy arranged for the bariatric wheelchair through [business name] (an application to order durable medical equipment) as I don't have access..."	F 660		

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F 660	Continued From page 27 When E11 was asked about community referrals, E11 stated, "I did not fax any referrals. I arranged for the transport home that she [R6] requested. That was it." 1/4/24 2:43 PM - During an interview, E3 (Clinical Specialist) stated, "Not having a social worker really caught us out ...". 1/5/24 1:56 PM - During a telephone interview, F1 (R6's son) stated, "She [R6] called 911 to take her to the hospital. She could not walk or get out of bed. One neighbor helped her with food and water. She was incontinent the whole time in the same diaper that she left the facility in." 1/5/24 2:49 PM - The facility was notified of an Immediate Jeopardy (IJ) with respect to R6's discharge. 1/5/24 5:22 PM - The abatement plan for this IJ was accepted by the State Agency. This abatement plan included: -review of the Discharge Summary and Plan policy, education of 100% of Nursing and Administrative staff regarding the discharge planning process, audits of all current residents and all discharges in the last 30 days to ensure appropriate discharge planning is in placed or occurred, contacting all residents discharged in the last 30 days to ensure all care service referrals were completed, the creation of a Discharge Planning process checklist, the initiation and completion of the Discharge Assessment within 72 hours of admission, the coordination of post-discharge follow up appointments by the facility, scheduled calls to discharged residents to monitor their success in the community, and IDT (interdisciplinary team) review of all discharges.	F 660		

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F 660	Continued From page 28 1/8/24 12:30 PM - Findings were reviewed with E1 (NHA), E2 (ADON), E3 (Clinical specialist), E4 (acting ADON) and E14 (DON). 1/8/24 12:46 PM - The facility alleged that the abatement was completed. The abatement was confirmed by reviewing the staff education sign in sheets, interviewing nurse staff regarding discharge education, reviewing audit sheets of last 30 day discharges, reviewing the Discharge Planning Process checklist and reviewing the scheduled IDT discharge review appointments.	F 660		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, observations and interviews, it was determined that for four (R3, R9, R19 and R21) out of six residents reviewed for respiratory care, the facility failed to provide respiratory care consistent with professional standards. R3 was sent to an outpatient appointment without enough supplemental oxygen to last for the duration of the excursion. R9, R19 and R21 all had oxygen compressors with dusty/dirty filters. R21's oxygen tubing was not changed as ordered. Findings include:	F 695	Corrective Action: Corrective actions have been ensured by the Director of Nursing. New clean oxygen concentrator filters were placed in the concentrators of R9, R19 and R21 immediately after the concern was identified. The oxygen tubing for R21 was replaced immediately after the concern was identified. Nursing staff were educated on the importance of ensuring	2/5/24

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F 695	Continued From page 29 1. Review of R3's clinical record revealed: 4/24/23 - R3 was admitted to the facility with diagnoses including, but were not limited to, COPD, congestive heart failure (CHF) and respiratory failure with hypoxia. 4/24/23 - E7 (DO) placed an order in R3's EMAR stating, "Continuous Oxygen @4 liters/min (minute) via nasal cannula to maintain pulse ox above 92% every shift." E7 (DO) also placed another order stating, "Change O2 tubing and humidifier bottle every Monday 11-7 (shift). Date, time, and initial tubing (as a nursing measure) every night shift every Mon." 4/24/23 - E7 (DO) wrote an order in R3's chart stating, "Cardiology appointment with MD [E18] on 5/1/23 at 1:15 PM. [Cardiology office address] Newark DE 19713." 4/25/23 - E7 (DO) gave a verbal order regarding R3 stating, "Pulse ox, lung assessment, full vitals and assessment progress note every shift for SOB (shortness of breath) monitoring." 4/28/23 - The admission Minimum Data Set (MDS) evaluation documented R3's Basic Inventory of Mental Status (BIMS) score as 13, which was reflective of normal cognition. 5/1/23 - R3 was transported to [Cardiology office] by the facility's bus wearing supplemental oxygen being delivered by a portable tank. 5/1/23 4:17 PM - E4 (acting ADON) documented in a general note " ...[R3] at the [Cardiology office] and was transported by the facility's bus.	F 695	all oxygen concentrators have clean filters and the oxygen tubing has been replaced and labeled, as ordered. R3 ran out of supplemental oxygen when out of the community for an outpatient appointment. Education of all Nursing staff was conducted regarding the need to ensure that any resident leaving the community for an outpatient appointment has enough supply of supplemental oxygen for the duration of the time that he/she/they are out of the community. Identification of Other Residents: · All Residents have the potential to be affected. Other residents will be protected by ensuring that all oxygen concentrator filters are replaced with a new filter on a weekly basis and oxygen tubing is replaced and labeled with the date, as ordered. Also, all residents going out for an appointment will have enough supplemental oxygen to last through the duration of their trip. 100% audit of all oxygen concentrators has been completed to ensure that all concentrators have a clean filter in place and that the oxygen tubing was replaced and labeled with the date, as ordered. No new concerns regarding oxygen concentrator filters and tubing including the label were identified as a result of this audit. No other resident has been identified as running out of supplemental oxygen during an outpatient appointment since time of survey. System Changes:	

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F 695	Continued From page 30 Received call from the [Cardiology] office at about 1:28 PM stating the resident [R3] was done and that the driver stated that he was not in the area. Educated her [Cardiology office staff member] the driver had other residents to drop off and will be picking her [R3] up. The [Cardiology] office stated someone was supposed to accompany resident according to their office policy but that was not (sic) communicated to the (facility) scheduler when she called to confirm the appointment. Received another call from the [Cardiology] office at about 2:50 PM stating the driver had arrived to pick the resident [R3] up and the resident's oxygen was out ... I [E4 acting ADON] took oxygen to the office ...F2 (R3's grandson) stated he [F2] wanted to take her [R3] home and the nurse [E19] at the doctor's office suggested resident [R3] be taken to the ER so social services could get involved and set up home care. Apologized to grandson [F2] about everything and resident [R3] was taken to Christiana ER." The facility failed to assure that R3 had enough portable supply of oxygen to last the duration of her excursion to her Cardiologist's office. 5/1/23 - R3 was admitted to the hospital with diagnosis of gastrointestinal bleed. 1/2/23 2:50 PM - During a telephone interview, E19 (RN Nurse manager Cardiology office) read from her notes regarding the incident with R3 on 5/1/23, " ... [R3] from [facility] unattended without oxygen for 4 hours. She [R3] had an accident and had to be cleaned up. Called facility multiple times. Was admitted [to the hospital] for GI bleed. Was on supplemental oxygen."	F 695	· The Root Cause of the concern was a failure to check oxygen concentrators for the presence of clean oxygen concentrator filters and that the tubing was replaced, and labeled, based on the MD order. The facility system for weekly routine maintenance of oxygen concentrators was amended to include replacing filters weekly. The facility policy for "Departmental (Respiratory Therapy) – Prevention of Infection" was reviewed and found to meet professional standards. The Director of Nursing or Designee will complete education for all nursing staff regarding the policy for infection control considerations related to oxygen administration, oxygen concentrator filters and oxygen tubing, as well as sending enough oxygen when a resident goes out for the duration of the appointment. Any resident on supplemental oxygen will have the appropriate oxygen supply for the duration of their outpatient appointment. The nursing management team will provide oversight to ensure ongoing compliance. Success Evaluation: · An audit of a random sample of 10% of residents who have oxygen concentrators will be completed by the Director of Nursing or Designee to ensure that each concentrator has a clean filter, and that the oxygen tubing has been replaced as ordered. An additional audit will be completed to ensure all residents on oxygen have enough oxygen to last for	

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F 695	Continued From page 31 1/2/24 3:19 PM - This surveyor received an email from E19 (RN Cardiology Nurse manager), which stated, "I did review [R3's] chart with my MA (medical assistant) manager and she also cannot confidently state that she came here without oxygen (replacement tank)." 2. Review of R9's clinical record revealed: 11/9/17 - R9 was admitted to the facility with diagnoses including, but were not limited to, pulmonary fibrosis, chronic obstructive pulmonary disease (COPD), dementia and CHF. 11/22/22 - E7 wrote an order in R9's EMAR (electronic medical record) stating, "O2 (oxygen) via NC (nasal cannula) PRN (as needed) SOB (shortness of breath) or pulse ox (oximetry) < (less than) 92%." 1/3/24 9:52 AM - This Surveyor observed R9's supplemental oxygen compressor with a filter that was loaded with dust. This observation was confirmed by E17 (RN). 3. Review of R19's clinical record revealed: 5/17/19 - R19 was admitted to the facility with diagnoses including, but were not limited to, COPD, CHF and obstructive sleep apnea (OSA). 11/15/23 - E7 placed an order in R19's EMAR stating, "O2 2 L (liters)/min via nasal cannula continuous every shift related to COPD." 11/16/23 - E7 ordered, "Change and date O2 tubing and humidifier bottle every night shift every Monday" in R19's EMAR.	F 695	the duration of their trip. Audits will have a goal of 100% compliance; Audits will be completed weekly until 100% compliance is achieved for 3 consecutive evaluations, then every other week until 100% compliance is achieved for 3 consecutive evaluations, and then monthly until 100% compliance is achieved for 3 consecutive evaluations. Additional audits will be completed as needed based upon the level of compliance. The results of the audits will be reviewed by the Quality Assurance Team. An audit of residents out of the community for an appointment who are on supplemental oxygen will be conducted to ensure that 100% of all residents have enough supplemental oxygen for the duration of their outpatient appointment	

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F 695	Continued From page 32 1/3/24 9:57 AM - This Surveyor observed R19's supplemental oxygen compressor with a dirty and dusty filter. The oxygen tubing was not dated, but the humidifier water bottle was dated 1/2/24. R19 stated to the Surveyor, "Sometimes I clean it (the compressor filter) myself." These observations were confirmed by E17 (RN). 4. Review of R21's clinical record revealed: 1/28/22 - R21 was admitted to the facility with diagnoses including, but were not limited to, COPD, CHF and end stage renal disease with dependence on renal dialysis. 4/8/23 - E7 (DO) placed an order in R21's EMAR stating, "Oxygen 2 Liter/min via NC to maintain pulse ox (oximetry) > (greater than) 92% as needed for SOB (shortness of breath)/wheezing." 11/16/23 - E7 (DO) placed an order in R21's EMAR stating, "Change mask/cannula and tubing, water for humidification as needed and every night shift every Monday." 1/3/24 9:47 AM - This Surveyor observed R21's supplemental oxygen compressor with a dirty and dusty filter and the oxygen tubing attached to the compressor was dated 12/19/23. These observations were confirmed by E17 (RN). 1/8/24 12:30 PM - Findings were reviewed with E1 (NHA), E2 (ADON), E3 (Clinical specialist), E4 (acting ADON) and E14 (DON) at the exit conference.	F 695		
F 697 SS=D	Pain Management CFR(s): 483.25(k)	F 697		2/5/24

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F 697	Continued From page 33 §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require 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 record review and interviews, it was determined that for one (R5) out of four residents reviewed for Hospice care, the facility failed to provide pain management consistent with professional standards. R5, who was admitted to the facility on 5/19/23 on hospice services, did not receive any narcotic pain medication until four days after admission. Findings include: The facility's Pain Assessment and Management policy stated, "the pain management program is based on a facility-wide commitment to appropriate assessment and treatment of pain, based on professional standard of practice...Monitor the resident by performing a basic assessment with enough detail and, as needed, with standardized assessment tools (e.g. approved pain scales, etc)...". MED-PASS Revised March 2020 The pain management standards were approved by the American Geriatrics Society in April 2002 which included: appropriate assessment and management of pain; assessment in a way that facilitates regular reassessment and follow-up; same quantitative pain assessment scales should be used for initial and follow up assessment; set standards for monitoring and intervention; and collect data to monitor the effectiveness and appropriateness of pain management.	F 697	Corrective Action: " Corrective actions have been ensured by the Director of Nursing. R5 is no longer a resident in the facility. The Director of Nursing/designee has completed nursing staff education to prevent the recurrence of this concern. Identification of Other Residents: " All Residents have the potential to be affected. Other residents will be protected by ensuring that all reports of pain receive effective interventions and follow-up assessment to ensure effectiveness. A 100% audit of resident orders for pain medication has been completed to ensure proper assessment and management of pain, including post-analgesic pain assessments. No new concerns about pain management were identified from this audit. System Changes: " The Root Cause of the concern was a failure to assess and treat R5□s pain level. The facility system for daily clinical review meetings has been updated to include a review of resident pain scores to	

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F 697	Continued From page 34 Review of R5's clinical record: 5/14/23 10:58 PM - R5 was admitted to a hospital from another long-term care facility after a fall with a mental status change. During the trauma work up, R5's CT (computed tomography) scan revealed a pancreatic lesion with osteoblastic metastatic disease. R5's pain was managed with Dilaudid 0.3 mg IV push every 4 hrs PRN for pain (Equivalent of 30 mg Morphine) while in the hospital. 5/19/23 - R5 was admitted to the facility with diagnoses, including but were not limited to, multiple sclerosis, dementia and pancreatic lesion with osteoblastic (bone) metastatic disease. 5/19/23 4:49 PM - E20 (LPN) documented in R5's admission note stating, " ...Resident denies any pain or discomfort at this time ...". 5/19/23 - E7 (DO) gave a verbal order, "Monitor [R5's] pain level every shift". This order was signed off by the nurses in R5's Medication Administration Record (MAR). Review of the documentation in R5's MAR for May 2023 regarding "Monitor [R5's] pain level every shift" revealed twelve different nurses having documented a check during each shift for the dates of 5/19 to 5/26/23. Nurses' notes from 5/20/23 7:13 AM, 5/20/23 1:57 PM, 5/20/23 11:46 PM, 5/21/23 2:31 AM, 5/21/23 1:27 PM and 5/21/23 11:09 PM documented R5 "denies any pain or discomfort." 5/19/23 - E7 (DO) gave a verbal order, "Pain rating on a scale of 0-10 (as a nursing measure)	F 697	ensure effective pain assessment and management. The facility policy for Pain Assessment and Management was reviewed and found to meet professional standards. The Director of Nursing or Designee will complete education for all nursing staff regarding the policy for pain assessment and management. The nursing management team will provide oversight to ensure ongoing compliance. Success Evaluation: " An audit of a random sample of 10% of residents who have physician orders to treat pain will be completed by the Director of Nursing or Designee to ensure effective pain assessment and management; Audits will have a goal of 100% compliance. Audits will be completed daily until 100% compliance is achieved for a two-week period. Then weekly until 100% compliance is achieved for 3 consecutive evaluations, and then every other week until 100% compliance is achieved for 3 consecutive evaluations. Additional audits will be completed as needed based upon the level of compliance. The results of the audits will be reviewed by the Quality Assurance Team.	

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F 697	Continued From page 35	F 697		

every shift for pain". This order was documented on by the staff in R5's Treatment Administration Record (TAR).

Review of the documentation in R5's TAR for May 2023 regarding "Pain rating on a scale of 0-10 (as a nursing measure) every shift for pain" revealed twelve different nurses having documented a check, rather than the ordered pain scale of 0-10, during each shift for the dates of 5/19 to 5/26/23.

The facility's nurses failed to quantify with a number R5's pain as ordered using a scale of 0-10 (numerical rating scale).

5/19/23 - E7 (DO) gave a verbal order, "Acetaminophen Oral tablet (Tylenol) -give 650 mg by mouth every 6 hours as needed for mild pain 1-3." The administration of this medication was to be documented in R5's MAR.

Review of R5's MAR revealed only one dose of Tylenol 650 mg was given during R5's stay at the facility.
5/20/23 5:53 PM - E23's (NP) progress note documented, "History of present illness: ...Patient (R5) was also on Dilaudid in the hospital secondary to continued complaints of back pain with tachycardia. Unfortunately was also noted with osteoblastic metastatic disease and pancreatic disease ...Patient denies any pain although aide states patient had just stated that his back was bothering him ...Niece [F4] would like to continue with hospice care and would like patient's pain addressed ...Assessment & Plan: ... Back Pain- patient with complaints of back pain, history of the same, was previously on Dilaudid in the hospital and morphine prior to that, will restart morphine routine and as needed, did

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F 697	Continued From page 36 discuss with patient's niece [F4] ... will reach out to hospice regarding niece's concerns ...". Despite documenting that morphine pain medication was to be started, no order for narcotic pain medication was ordered. 5/22/23 12:32 - R5 was administered Tylenol 650 mg by mouth for abdominal pain, which was documented as "effective' in the follow up note at 2:36 PM. The facility could not provide any evidence of documentation of R5's pre- or post-pain scale with regarding to the administration of this pain medication. 5/22/23- Two days later, E23 (NP) ordered Morphine solution 20 mg/5 ml- give 0.25 ml (5 mg) PO (per mouth) every 4 hours PRN (as needed) for pain/SOB (shortness of breath) and give 0.25 ml (5 mg) two times a day for pain. This order scheduled R5 to receive morphine sulfate solution 20 mg/1 ml 0.25 ml (5 mg dose) at 9 AM and 9 PM with an order for breakthrough pain of 0.25 ml (5 mg dose) every 4 hours as needed. Duing an interview on 1/2/24, F4 (R5's niece) stated that due to concerns with care, R5's hospice care was transferred to another hospice agency. This was confirmed by E4 (acting ADON). 5/22/23 5:49 PM - C1 (RN) documented in R5's hospice care consultant initiation visit, " ...complains of pain all the time, only has Tylenol ordered ...This month after a fall, found malignant cancer ...".	F 697		

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F 697	Continued From page 37 5/23/23 2:12 PM - E7's (DO) admission History & Physical (H&P) for R5 documented, " ...imaging also did reveal bony mets (metastasis) from the cancer ... Hospice is seen (sic) patient, is requesting comfort medications to be started and initiated for patient, he is alert, confused , unable to answer questions appropriately ... Assessment & Plan: Adult failure to thrive- ...he is on hospice care, we will add morphine (pain medicine), Ativan (anxiety medicine), levsin (medication used to manage excessive oral secretions in dying patients) for patient comfort ..." This Surveyor obtained a copy of the [pharmacy] manifest documenting the first delivery of morphine sulfate 20 mg/1 ml solution as delivered to the facility on 5/23/23 at 3:36 AM. 5/23/23 9:00 AM- R5 received his first documented dose of morphine sulfate solution (narcotic pain medication) 1 mg by mouth, four days after admission to the facility. 5/24/23 - An admission Minimum Data Set (MDS) assessment documented R5's Basic Inventory of Mental status (BIMS) as three, which was reflective of severe cognition deficit. 5/25/23 - E7 (DO) ordered an increase in R5's pain medication to Morphine solution 20 mg/1 ml- give 5 mg PO (by mouth) every 4 hours as needed pain/SOB and give 5 mg PO every 8 hours for pain/SOB. This new order scheduled R5 to receive morphine sulfate solution 20 mg/1 ml 0.25 ml (5 mg dose) at 6 AM, 2 PM and 10 PM with an order for breakthrough pain of 0.25 ml (5 mg dose) every 4 hours as needed.	F 697		

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F 697	Continued From page 38 1/2/24 10:39 AM - During an interview, F4 (R5's niece) stated that she was not happy with {business name] hospice when R5 was admitted to the facility from the hospital so she opted to change to a different hospice provider within the first days of R5's stay at this facility. 1/4/24 11:02 AM - During an interview, E4 (acting ADON) stated, "Admission orders are written by the provider and then the unit clerk takes them off. If an order is written to monitor pain, unless the provider writes to mark the level reported, the order may not have a spot to document the level of pain that the resident reports. The check just documents that it was done." 1/8/24 12:30 PM - Findings were reviewed with E1 (NHA), E2 (ADON), E3 (Clinical specialist), E4 (acting ADON) and E14 (DON) at the exit conference.	F 697		
F 745 SS=D	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, it was determined that for one (R6) out of three residents reviewed for discharges, the facility failed to identify and provide R6 medically-related social services to maintain her highest practicable physical, mental and psychosocial well-being. Findings include:	F 745	Corrective Action: " Corrective actions have been ensured by the Director of Nursing. R6 is no longer a resident in the facility. The Director of Nursing/Designee has completed staff education to prevent a recurrence of failure to identify and provide medically	2/5/24

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F 745	Continued From page 39 Cross refer F625, example # 1, F644, and F660 Review of R6's clinical record revealed: 11/1/23 - R6's PASARR evaluation was completed prior to her admission to the nursing facility, which documented that R6 required the following specialized services within 30 days of admission: - an evaluation by a psychiatric Provider within 30 days of admission; and - a one-time psychiatric medication management evaluation by a Provider. R6's PASARR also documented that the following services and/or supports would need to be provided: - case management to explore community based living, family involvement or training in R6's care; - ongoing evaluations of the effectiveness of current psychotropic medications on target symptoms and a safety plan; and - if R6 returned to the community, the resident may need: 24-hour care and a safe place to live, someone to physically help you with mobility, assistance with your activities of daily living and care, and continued physical therapy/occupational therapy services. 11/3/23 - R6 was admitted to the facility with diagnoses including, but were not limited to morbid obesity, right elbow bursitis, weakness and major depressive disorder. 11/9/23 - An admission Minimum Data Set (MDS) documented R6's cognitive status as having a BIMS (Basic Inventory of Mental Status) score of 15, which is reflective of normal cognition. 11/30/23 2:38 PM - E11 (LSW) documented in a	F 745	related social services. Identification of Other Residents: " All Residents have the potential to be affected. A new full-time Social Worker started working at Shipley Living on 1/3/24. In order to prevent other residents from being affected, all nursing and social services staff members will be trained on the requirements for making referrals to ensure a safe discharge and to maintain the highest practicable physical, mental and psychosocial well-being of our residents. System Changes: " The Root Cause of the concern was a failure to provide R6 with medically related Social Services. The facility did not have a full time Social Worker at the time of the incident. A new full-time Social Worker started employment at Shipley Living on 1/3/24. In the absence of Social Service staff, the AL Director will be responsible for ensuring medically related social services are provided. Success Evaluation: " A 100% audit of all current residents was conducted to assess the need for Social Services. The recently hired Social Service Director will meet with all residents recently admitted and those preparing for discharge to assess their current and ongoing need for services. Subsequent audits of 50% of upcoming	

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F 745	Continued From page 40 Social Services Note in R6's EMAR, " ...Resident [R6] was requesting to speak to SW (social work) ...I introduced myself and stated who I was as this was my first time meeting the resident. R6 had been in the facility 27 days at the time of her first encounter with a social worker. The facility was not able to provide evidence of any other facility employee who provided medically related social services such as referrals to community based case management, psychotropic medication evaluations, discharge safety plan with regard to R6. 12/2/23 11:00 AM - R6 was discharged home via stretcher by a [transport company] ambulance. 1/3/24 3:23 PM- During an interview, E4 (acting ADON) stated, "We did not have a full-time social worker. E11, the Social Worker from [another facility], came in 2 days a week to cover the facility. I am not sure which days E11 comes to our building." 1/4/24 10:26 AM - During an interview, E11 (Social Worker) stated, "First time I met her [R6] was on 11/30/23 (Thursday), she [R6] said I need you [E11] to arrange transport with [transport company] at 11 am on Saturday (12/2/23) and bariatric wheelchair. E11 stated, "My other building does not do Medicaid pending. So that was not on my radar. I did not even know she had a PASARR II." When E11 was asked about community referrals, E11 stated, "I did not fax any referrals. I arranged for the transport home that she [R6] requested. That was it."	F 745	discharges will have a goal of 100% compliance; Audits of 50% of upcoming discharges will be completed weekly until 100% compliance is achieved for 3 consecutive evaluations, then every other week until 100% compliance is achieved for 3 consecutive evaluations, and then monthly until 100% compliance is achieved for 3 consecutive evaluations. Additional audits will be completed as needed based upon the level of compliance. The results of the audits will be reviewed by the Quality Assurance Team. In the absence of Social Service staff, the AL Director will be responsible for ensuring medically related social services are provided.	

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F 745	Continued From page 41 The facility failed to educate R6 of her option to apply for Medicaid and stay in a LTC setting with a "Medicaid pending" status. The facility failed to provide evidence of referrals for needed community services upon transition from the facility. 1/4/24 11:35 AM- During an interview, E4 (acting ADON) stated, "No, I did not find any psych notes for R6. I called the Psych NP [E6] to see if she has any. We did have GDR (gradual drug reduction) meeting on 12/13/23 but she [R6] was gone (discharged) by then." 1/4/24 2:43 PM - During an interview, E3 (Clinical Specialist) stated, "Not having a social worker really caught us out ...". 1/5/24 10:54 AM - Electronic message (text) from E5 (Psychiatrist) stated, "I tried to call you back. I don't see patients but my NP [E6] goes there. When I went to do GDR, patient [R6] was already discharged. So I am sorry I don't know the patients (sic)." 1/5/24 4:43 PM -During a telephone interview, E6 (E5's Psych NP) stated, " I checked my billing records. I did not see R6 listed so I did not see her [R6]." Both E5 (Psychiatrist) and E6 (Psych NP) confirmed that they did not have any encounters with R6 not evaluated her medications' effectiveness as required by R6's PASARR. The facility failed to arrange and provide PASARR required and needed mental health social services during R6's stay. 1/8/24 11:05 AM -During an interview, E3 (Clinical	F 745		

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F 745	Continued From page 42 specialist) stated, "We were without a social worker for months." The facility failed to ensure that the medically related services (such as PASARR review, transition of care referrals) typically provided by the social worker were reassigned in the absence of a designated social worker. 1/8/24 12:30 PM - Findings were reviewed with E1 (NHA), E2 (ADON), E3 (Clinical specialist), E4 (acting ADON) and E14 (DON) at the exit conference.	F 745		
F 919 SS=D	Resident Call System CFR(s): 483.90(g)(1)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from- §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that for one (R7) out of three residents reviewed for call lights, the facility failed to ensure a functioning call bell system. Findings include: 10/9/17 - R7 was admitted to the facility with diagnoses including, but not limited to, Down Syndrome, HTN, non-Alzheimer's dementia and depression.	F 919	Corrective Action: " Corrective actions have been ensured by the Administrator, the Director of Nursing, and the Director of Maintenance. R7 experienced no adverse effects regarding the call bell malfunctioning. Maintenance staff have been educated on ensuring all call bells are working. All staff have been educated not to wrap the call light cord around the railings.	2/5/24

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F 919	Continued From page 43 Review of R7's annual and quarterly MDS respectively documented independence for toileting. 1/4/24 at 10:23 AM - The call light in R7's bathroom did not light up when the cord was pulled by this surveyor to check call light functioning. After three separate pulls on the cord, the light still did not come on. It was noted that the cord was wrapped multiple times around the bathroom rail. E15 (CNA) was asked how R7 calls to get help if needed in the bathroom. Per E15, she [R7] would pull the cord. E15 was asked to demonstrate and upon pulling on the cord said, "It's not coming on." E15 was then heard contacting maintenance. 1/4/24 at 12:30 PM - E2 (ADON) and E16 (maintenance technician) presented the cord saying, "It worked but the cord had been wrapped around the railing which had kept it from working." 1/4/24 at 12:45 PM - E4 (Director of Assisted Living) was interviewed and asked why a cord was wrapped around the rail in the bathroom. Per E4, "I guess the cord was too long." After stating to E4 (Director of Assisted Living) that if the resident needed to use the call light it would not have worked, E4 stated, "We'll have to in-service the staff." 1/8/24 at 12:30 PM - Findings were reviewed with E1 (NHA), E2 (ADON), E3 (Clinical specialist), E4 (acting ADON) and E14 (DON) at the exit conference.	F 919	Identification of Other Residents: " All Residents have the potential to be affected by the alleged deficient practice. A 100% audit was completed upon discovery of this alleged deficiency to ensure that all resident call lights were properly functioning, and call light cords were not wrapped around the railings. System Changes: " The root cause of this concern was failure to identify a malfunctioning call light. " Call light cords will no longer be wrapped around the railing. " The facility policy for call lights was reviewed and found to meet professional standards. Success Evaluation: " An initial 100% audit of all call lights has been completed by the Maintenance Director/Designee to ensure that all call lights are functioning and that no call light cords were wrapped around a railing; Additional Audits will be completed by the Director of Maintenance/Designee on 25% of call bells; Audits will have a goal of 100% compliance; Audits will be completed weekly until 100% compliance is achieved for 3 consecutive evaluations, then every other week until 100% compliance is achieved for 3 consecutive evaluations, and then monthly until 100% compliance is achieved for 3 consecutive	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085031	A. BUILDING _____ B. WING _____	C 01/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 919	Continued From page 44	F 919	evaluations. Additional audits will be completed as needed based upon the level of compliance. The results of the audits will be reviewed by the Quality Assurance Team.	