



**DELAWARE HEALTH
AND SOCIAL SERVICES**

Division of Long Term Care
Residents Protection

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

STATE SURVEY REPORT

Page 1 of 46

NAME OF FACILITY: Country Rest Home

DATE SURVEY COMPLETED: February 3, 2017

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
---------	--	---	--------------------

	<p>The State Report incorporates by reference and also cites the findings specified in the Federal Report.</p> <p>An unannounced annual and complaint survey was conducted at this facility beginning January 31, 2017 and ending February 3, 2017. The facility census on the entrance day of the survey was 47 residents. The survey sample was composed of 12 residents. The survey process included observations, interviews and review of residents' clinical records, facility documents and facility policies and procedures.</p> <p>Abbreviations used in this report are as follows:</p> <p>NHA - Nursing Home Administrator; DON - Director of Nursing; ADON - Assistant Director of Nursing; RN - Registered Nurse; LPN - Licensed Practical Nurse; UM - Unit Manager; MD - Medical Doctor; RNAC - Registered Nurse Assessment Coordinator; CNA - Certified Nurse's Aide; FSD - Food Service Director; RD - Registered Dietitian; NP - Nurse Practitioner; PA - Physician Assistant; QA - Quality Assurance; > - more than; < - less than; = - equal; + - plus; 0 - 10 Pain Scale - number scale to rate pain where 0 is no pain and 10 is the worst possible pain;</p>		
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Provider's Signature Mark York, Jr. Title Administrator Date 5/1/17



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Division of Long Term Care
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STATE SURVEY REPORT

Page 2 of 46

NAME OF FACILITY: Country Rest Home

DATE SURVEY COMPLETED: February 3, 2017

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
---------	--	---	--------------------

	<p>ADLs - Activities of Daily Living, such as bathing and dressing; Alprazolam (Xanax) – medication to treat anxiety; Ambulation – moving about; walking; Anxiety - general unpleasant state of feeling worry, nervous or restless; Bid –twice a day; Bisacodyl – medication for constipation; Cath – catheter; Chem 7 – blood test to determine the body's metabolism; Coreg – medication to treat high blood pressure; DLTCRP – the Delaware Division of Long Term Care Residents Protection; DSD – dry sterile dressing; eMAR - Electronic Medication Administration Record; EMR - Electronic Medical Record; ER – emergency room; Foley – indwelling urinary catheter; F/U – follow-up; HS – at bedtime; Lasix – remove excess fluid medication; mg (Milligram) - metric unit of weight, 1 mg equals 0.0035 ounce; NAS – no added salt; NSS – normal saline solution; Pressure Ulcer (PU) - sore area of skin that develops when blood supply to it is cut off due to pressure; PRN - As needed; Proteus – type of bacteria.</p>		
3201	Regulations for Skilled and Intermediate Care Facilities		
3201.1.0	Scope		
3201.1.2	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		

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STATE SURVEY REPORT

Page 3 of 46

NAME OF FACILITY: Country Rest Home

DATE SURVEY COMPLETED: February 3, 2017

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
---------	--	---	--------------------

	<p>amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.</p> <p>This requirement is not met as evidenced by:</p> <p>F156</p> <p>§483.10(d)(3) The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care. §483.10(g) Information and Communication.</p> <p><i>(1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility.</i></p> <p>§483.10(g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including:</p> <p><i>(i) Required notices as specified in this section.</i> The facility must furnish to each resident a written description of legal rights which includes</p> <p><i>(A) A description of the manner of protecting</i></p>		
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Provider's Signature [Signature] Title Administrator Date 5/1/17



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DHSS - DLTCRP
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(302) 577-6661

STATE SURVEY REPORT

Page 4 of 46

NAME OF FACILITY: Country Rest Home

DATE SURVEY COMPLETED: February 3, 2017

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
---------	--	---	--------------------

	<p>personal funds, under paragraph (f)(10) of this section;</p> <p>(B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act.</p> <p>(C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and</p> <p>(D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non compliance with the advance directives requirements and requests for information regarding returning to the community.</p> <p>(ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care</p>		
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Provider's Signature Mark G. [Signature] Title Administrator Date 5/1/17



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3 Mill Road, Suite 308
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STATE SURVEY REPORT

Page 5 of 46

NAME OF FACILITY: Country Rest Home

DATE SURVEY COMPLETED: February 3, 2017

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
---------	--	---	--------------------

	<p><i>Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.) [§483.10(g)(4)(ii) will be implemented beginning November 28, 2017 (Phase 2)]</i></p> <p><i>(iii) Information regarding Medicare and Medicaid eligibility and coverage; [§483.10(g)(4)(iii) will be implemented beginning November 28, 2017 (Phase 2)]</i></p> <p><i>(iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program; [§483.10(g)(4)(iv) will be implemented beginning November 28, 2017 (Phase 2)]</i></p> <p><i>(v) Contact information for the Medicaid Fraud Control Unit; and [§483.10(g)(4)(v) will be implemented beginning November 28, 2017 (Phase 2)]</i></p> <p><i>(vi) (vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the</i></p>		
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Provider's Signature Martha J. [Signature] Title Administrator Date 5/1/17



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STATE SURVEY REPORT

Page 6 of 46

NAME OF FACILITY: Country Rest Home

DATE SURVEY COMPLETED: February 3, 2017

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
---------	--	---	--------------------

	<p><i>community.</i></p> <p>§483.10(g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives:</p> <p><i>(i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and</i></p> <p><i>(ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community.</i></p> <p>§483.10(g)(13) The facility must display in the facility written information, and provide to residents and applicants for admission, oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p>		
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Provider's Signature *Marilyn J. ...* Title Administrator Date 5/1/17



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AND SOCIAL SERVICES**

Division of Long Term Care
Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
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STATE SURVEY REPORT

Page 7 of 46

NAME OF FACILITY: Country Rest Home

DATE SURVEY COMPLETED: February 3, 2017

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
---------	--	---	--------------------

	<p>§483.10(g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay.</p> <p>(i) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility.</p> <p>(ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any.</p> <p>(iii) Receipt of such information, and any amendments to it, must be acknowledged in writing;</p> <p>§483.10(g)(17) The facility must--</p> <p>(i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of—</p> <p>(A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged;</p> <p>(B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and</p> <p>(ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in paragraphs (g)(17)(i)(A) and (B) of this section.</p> <p>§483.10(g)(18) The facility must inform</p>		
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Provider's Signature *Mar. M. [Signature]* Title Administrator Date 5/1/17



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Residents Protection

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3 Mill Road, Suite 308
Wilmington, Delaware 19806
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STATE SURVEY REPORT

Page 8 of 46

NAME OF FACILITY: Country Rest Home

DATE SURVEY COMPLETED: February 3, 2017

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
---------	--	---	--------------------

	<p>each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.</p> <p><i>(i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.</i></p> <p><i>(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.</i></p> <p><i>(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.</i></p> <p><i>(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility.</i></p> <p><i>v) The terms of an admission contract by or on</i></p>		
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Residents Protection

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3 Mill Road, Suite 308
Wilmington, Delaware 19806
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STATE SURVEY REPORT

Page 9 of 46

NAME OF FACILITY: Country Rest Home

DATE SURVEY COMPLETED: February 3, 2017

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
---------	--	---	--------------------

	<p><i>behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations.</i></p> <p>This requirement is not met:</p> <p>Based on observations and staff interview, it was determined that the facility failed to post the State Survey Agency phone number (DLTCRP) or the hotline number to report abuse in a place visible to all residents, visitors and staff. Findings include:</p> <p>Observation on 1/31/17 during the initial tour of the facility at around 9:00 AM, the Survey Team did not observe anywhere in the facility the State Survey Agency phone number (DLTCRP) or the hotline number to report abuse.</p> <p>During an interview with E3 (administrative assistant) on 2/02/17 at 3:00 PM these finding were confirmed. E3 stated this would be corrected.</p> <p>These findings were reviewed with E1 (NHA) and E4 (DON) on 2/03/17 at 11:00 AM during exit the conference.</p> <p>F167 §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for</p>	<p>F156</p> <p>The state provided posters that included the phone number to DLTCRP and the hotline number to report abuse was posted on 2/6/17 in areas that were visible to all residents, visitors and staff. The administrative assistant will monitor monthly to make sure the posters remain posted.</p>	<p>2/6/2017</p>
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3 Mill Road, Suite 308
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(302) 577-6661

STATE SURVEY REPORT

Page 10 of 46

NAME OF FACILITY: Country Rest Home

DATE SURVEY COMPLETED: February 3, 2017

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
---------	--	---	--------------------

	<p><i>any individual to review upon request; and</i> <i>(iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public.</i> <i>(iv) The facility shall not make available identifying information about Complainants or resident.</i></p> <p>This requirement is not met:</p> <p>Based on observations and staff interview, it was determined that the facility failed to have a notice posted as to the location of the most recent State Survey results and failed to have the survey results available for examination in a place readily accessible to all residents and visitors. Findings include:</p> <p>Observation on 1/31/17 during the initial tour of the facility at around 9:00 AM, the Survey Team located the survey results in a magazine rack on the wall behind furniture in the new building lobby. The results were not easily visible. A posting as to the location of the survey results was not observed anywhere in the facility.</p> <p>During an interview with E11 (Assistant NHA) on 2/02/17 11:00 AM, these findings were confirmed.</p> <p>During an interview with E3 (administrative assistant) on 2/02/17 at 03:00 PM these finding were confirmed. E3 stated this would be corrected.</p> <p>These findings were reviewed with E1 (NHA) and E4 (DON) on 2/03/17 at 11:00 AM during exit conference.</p> <p>F225</p> <p>§ 483.12(a) The facility must— (3) Not employ or otherwise engage individuals who— (i) Have been found guilty of abuse, neglect,</p>	<p>F167</p> <p>Notices were posted in visible areas for residents and visitors stating the location of the last 3 years survey results. The magazine rack which held the survey results was relocated for better access. The administrative assistant will monitor monthly to ensure that the notice and the survey results are kept available for all residents and visitors in the future.</p>	<p>4/04/17</p>
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Provider's Signature Mark L. Jordan, Jr. Title Administrator Date 5/1/17



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Residents Protection

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

STATE SURVEY REPORT

Page 11 of 46

NAME OF FACILITY: Country Rest Home

DATE SURVEY COMPLETED: February 3, 2017

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
---------	--	---	--------------------

	<p><i>exploitation, misappropriation of property, or mistreatment by a court of law;</i></p> <p><i>(ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or</i></p> <p><i>(iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property.</i></p> <p>(4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff.</p> <p>This requirement is not met: Based on review of facility documentation and interview it was determined that the facility failed to immediately report an allegation of abuse/mistreatment concerning one (R6) out of 12 sampled residents. Findings include: Cross refer F226.</p> <p>The facility's policy for Allegations of Abuse included an attached list of reportable incidents / potential abuse. This document stated that these incidents would be communicated within eight hours of the incident to the Division of Long Term Care Residents Protection.</p> <p>Review of the facility investigation of an allegation of abuse incident for R6 documented that on 3/10/16 at 8:30 PM: During resident care while CNA (E8) was trying to reposition resident[R6], resident slapped CNA[E8] across the face. CNA impulsively reacted by</p>	<p>F225-Cross refer F226 The facility administration and Nursing staff have been given a review of reportable incidents, one on one. Nursing staff have been instructed to immediately report all allegations of abuse/mistreatment concerning any resident. All nursing staff will now able to communicate knowledge of the eight hour window in which to report allegations of abuse to the state, DLTCRP. The nursing staff are learning how to report incidents/allegations of abuse to the state and have been provided the link with our facility code. This corrective action ensures state reporting to be completed within the eight hours required. The DON will monitor the process weekly to be sure all staff follows the guidelines.</p>	<p>04/10/2017</p>
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Provider's Signature [Signature] Title Administrator Date 5/1/17



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3 Mill Road, Suite 308
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STATE SURVEY REPORT

Page 12 of 46

NAME OF FACILITY: Country Rest Home

DATE SURVEY COMPLETED: February 3, 2017

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
---------	--	---	--------------------

	<p>slapping resident back an action CNA immediately regretted. While the slap was not hard and there was no injury we recognize this is a reportable incident. The CNA has been reprimanded and an abuse in-service was completed before the end of her shift. We feel that we have taken appropriate action in dealing with this situation but in keeping with policy are reporting the incident.</p> <p>This report was not sent to DLTCRP until 3/16/16.</p> <p>During an interview on 2/2/17 at 12:30 PM with E3 (Administrative Assistant) and E4 (DON) confirmed that the incident from 3/10/16 was not immediately reported to DLTCRP.</p> <p>These findings were reviewed with E1 (NHA) and E4 on 2/3/17 at 11:00 AM.</p> <p>F226 ** 483.12(b) The facility must develop and implement written policies and procedures that:</p> <p><i>(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,</i></p> <p><i>(2) Establish policies and procedures to investigate any such allegations, and</i></p> <p><i>(3) Include training as required at paragraph §483.95,</i></p> <p><i>(4) Establish coordination with the QAPI program required under §483.75.</i></p> <p><i>[§483.12(b)(4) will be implemented beginning November 28, 2019 (Phase 3)]</i></p> <p>§483.95(c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also</p>		
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Provider's Signature *Mark Johnson* Title Administrator Date 5/1/17



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

STATE SURVEY REPORT

Page 13 of 46

NAME OF FACILITY: Country Rest Home

DATE SURVEY COMPLETED: February 3, 2017

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
---------	--	---	--------------------

	<p>provide training to their staff that at a minimum educates staff on—</p> <p>§483.95(c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12.</p> <p>§483.95(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property</p> <p>§483.95(c)(3) Dementia management and resident abuse prevention.</p> <p>This requirement is not met: Based on review of facility documents and interview it was determined that the facility failed to develop abuse prohibition policies that included protection of residents. The facility also failed to ensure staff was provided training to prevent abuse. Findings include:</p> <p>Cross refer F225.</p> <p>The facility's policy and procedure for Allegation of Abuse last revised 1/2017 lacked any information about the protection of residents from the accused when an allegation is made.</p> <p>The policy identified staff training in this policy by documenting "Educational in-service will be held on resident abuse upon hire, yearly and review as needed..."</p> <p>The policy also included the statement "All staff is required to report concerns of possible verbal or physical abuse of a resident..."</p> <p>E9 (CNA) was hired on 11/23/15. Review of in-services</p>	<p>F226</p> <p>. See Attachment 1-A The facility policy on, Allegations of Abuse, has been revised and reviewed with all staff.</p> <ol style="list-style-type: none"> 1. The revised policy objective clearly states that all residents will be protected from all types of abuse, listed with definitions. The revised policy includes prevention measures through education/training and monitoring of staff for stress/anxiety or signs of 'burn out'. 2. Protection of the residents from the accused, during allegations of abuse, has been added to our policy and reviewed with all staff. Page 2 of policy attachment 1-A. 3. All staff will be provided education on abuse upon hire, annually and reviewed as needed. The DON will monitor adherence to our policy upon hire and annually. 	<p>3/7/2017</p>
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Provider's Signature *Mark Updegraff* Title Administrator Date 5/1/17



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Division of Long Term Care Residents Protection

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3 Mill Road, Suite 308
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(302) 577-6661

STATE SURVEY REPORT

Page 14 of 46

NAME OF FACILITY: Country Rest Home

DATE SURVEY COMPLETED: February 3, 2017

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	<p>provided on hire lacked evidence that abuse training was conducted.</p> <p>E8 (CNA) was hired on 12/21/15. Review of in-services provided on hire lacked evidence that abuse training was conducted. E8 did not receive abuse training until 3/11/16 after an allegation of abuse/mistreatment was made concerning this employee.</p> <p>Review of a facility investigative packet for R6 revealed that on 3/10/16 at 8:30 PM E9 observed E8 slap R6 in response to the resident slapping the aide during care. A statement from E3 [Administrative Assistant] documented that on the morning of 3/11/16 she received a text from E9 who stated she needed to talk to E4 (DON). The statement further described the reported incident. The packet also included the state reporting form that was submitted on 3/16/16. E9 failed to report the slapping incident on 3/10/16 when it happened; instead she contacted administration the next morning. The facility failed to report the allegation until 3/16/16.</p> <p>During an Interview on 2/1/17 at 2:45 PM with E4 it was confirmed that E8 did not have abuse training on hire. E4 also confirmed that no training was done with E9, who witnessed the slap after the incident. E4 later revealed that E9 also had no abuse training on hire. E4 confirmed that the incident happened on 3-11 shift 3/10/16 and E9 text E4 early in morning 3/11/16 to speak with E4 when s/he arrived to work.</p> <p>The facility failed to ensure staff was educated on abuse prohibition, the facility failed to ensure staff immediately reported allegations of suspected abuse or mistreatment, the facility failed to ensure their policy addressed resident protection when an allegation is made.</p> <p>These findings were review with E1 (NHA) and E4 on 2/3/17 at 11:00 AM</p>	<p>F226 The nursing staff has been given a review regarding allegations of abuse, witness of abuse or suspicion of abuse. All staff are to report to the DON or Administration as soon as possible. The nursing staff is aware of our policy and the state requirements to report all reportable incidents, allegations of abuse, to the state within 8 hours. The nursing staff have been provided a link to the state, DLTCRP. The DON will review/train each nurse how to report incidents to the state. This corrective measure will ensure reporting allegations of abuse can be completed without waiting for administration or the DON. The DON and administration will monitor in the future, weekly, that our policy and training are being followed. The QAP will include monitoring via a print out of all state submissions for date and time of report for continued improvement daily when incidents are reported.</p>	<p>04/01/2017</p>

Provider's Signature *Mark Fisher Jr* Title Administrator Date 5/1/17



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Division of Long Term Care
Residents Protection

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3 Mill Road, Suite 308
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(302) 577-6661

STATE SURVEY REPORT

Page 15 of 46

NAME OF FACILITY: Country Rest Home

DATE SURVEY COMPLETED: February 3, 2017

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
---------	--	---	--------------------

	<p>F241 §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.</p> <p>This requirement is not met:</p> <p>Based on observation it was determined that the facility failed to provide care in a respectful and dignified manner for 5 (R8, R9, R10, R11 and R12) out of 12 sampled residents. For R8, R11 and R12 their urinary catheter drainage bag was uncovered during meals in the dining room. For R9 and R10 staff entered the resident's room without knocking or requesting permission to enter. Findings include:</p> <p>Uncovered urinary catheter drainage bag</p> <p>1. R12 was observed eating lunch (12:00 PM – 12:30 PM) in the dining room with the urine in the drainage bag visible beneath the resident's wheelchair on:</p> <ul style="list-style-type: none"> - 1/31/17 - 2/1/17 - 2/2/17 <p>2. 2/2/17 observations of R11 with visible in the drainage bag</p> <ul style="list-style-type: none"> - 8:15 AM during breakfast while drainage bag hanging on the arm of the dining room chair. - 9:00 AM while ambulating with a walker by the nursing station with the drainage bag hanging on the right lower bar on the walker. - 12:00 PM during lunch with the drainage bag hanging on the arm of the dining room chair. <p>3. R8 was observed:</p> <ul style="list-style-type: none"> -1/31/17 11:45 AM to 12:15 PM R8's urinary drainage bag hanging on chair uncovered. -1/31/17 2:22 PM, R8's urinary drainage bag remained 	<p>F241</p> <p>1. The facility policy for foley care has been updated/ revised to include that all urinary collection bags will be covered to protect the resident's dignity. See attachment 1-B. Residents that are up and about will have a leg bag during the day. Residents unable to use a leg bag will have their urinary collection bags covered at all times. The DON will monitor the residents with urinary collection bags for policy compliance.</p> <p>2. The facility policy also includes a review of catheter care and correct handling of collection bags for proper drainage. All of the NA have had a recent review of catheter care, drainage bag change and proper placement of the drainage bag as well as when to use a leg bag. This in-service included the covering of collection bags for privacy. The DON will monitor daily the resident's collection bags for proper placement and coverage. See attachment 1-C in-service check list and sign in sheet.</p>	<p>3/15/2017</p>
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Provider's Signature Mark Yobers Title Administrator Date 5/1/17



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Division of Long Term Care
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Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

Page 16 of 46

NAME OF FACILITY: Country Rest Home

DATE SURVEY COMPLETED: February 3, 2017

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
---------	--	---	--------------------

	<p>uncovered. -2/2/17 9:00 – 9:30 AM R8 observed in dayroom with the urinary drainage bag uncovered.</p> <p>4. Random observations on 2/2/17 on the New Unit of staff entering a resident's room without knocking or requesting/ waiting for permission to enter. Both residents were alert and capable of answering appropriately.</p> <p>-8:40 AM E6 (RN) entered R9's room to perform dressing changes without knocking or asking/waiting for permission to enter. -9:30 AM E7 (CNA) entered R9's room to perform his bath without knocking or asking/waiting for permission to enter. -10:30 AM E5 (LPN) entered R10's room to perform dressing changes without knocking or asking/waiting for permission to enter.</p> <p>These findings were reviewed with E1 (NHA) and E4 [DON] on 2/3/17 at 11:00 AM.</p> <p>F309 § 483.24 Quality of life <i>Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care.</i></p> <p>§ 483.25 Quality of care <i>Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents'</i></p>	<p>F241 4. The facilities staff have all had a review of resident privacy and that entering their rooms must be part of protecting the residents privacy, by waiting for permission to enter. All staff are to knock on the resident's door, even if opened. This procedure has been verbally reviewed and a message sent to all nursing staff as a reminder via message system within the EMR as a immediate reminder. The DON will monitor daily all staff behavior for privacy protection, by direct observation of 'knocking' first prior to entering daily. See attachment of message 1-D</p>	<p>3/7/2017</p>
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Division of Long Term Care
Residents Protection

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

STATE SURVEY REPORT

Page 17 of 46

NAME OF FACILITY: Country Rest Home

DATE SURVEY COMPLETED: February 3, 2017

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
---------	--	---	--------------------

	<p><i>choices, including but not limited to the following:</i></p> <p>§483.25(k) Pain Management. <i>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.</i></p> <p>§483.25(l) Dialysis. <i>The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.</i></p> <p>483.40(b)(3) <i>A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. [§483.40(b)(3) will be implemented beginning November 28, 2017 (Phase 2)]</i></p> <p>This requirement is not met:</p> <p>Based on record review and interview it was determined that the facility failed to adequately assess pain before and after PRN pain medication for 1 (R3) out of 12 sampled residents. In addition, for one (R7) out of 12 sampled residents the facility failed to ensure medications were administered as ordered by the physician. Findings include:</p> <p>1. Undated policy entitled <i>Pain Assessment</i> (last reviewed by DON 7/16/16) described the 0 - 10 pain scale as well as the non-verbal pain indicator checklist. The appropriate number from the non-verbal pain indicator checklist will be documented on the MAR. If a resident requires pain medication, a nurses' note is to be written also, indicating the symptoms noted and what relief notes after the intervention..... If a resident has</p>	<p>F309 See attachment 1-E 1. The facility pain assessment policy has been revised. The policy does now read that all residents are to have pain assessment every shift and as needed. The staff has been educated on how to select the protocol for re-assessment of pain medication effectiveness. This selection will remind the staff to chart the effectiveness in the EMR. I have also reviewed with the nursing staff.....cont. on next page.</p>	<p>4/01/2017</p>
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Provider's Signature *Mark G. ...* Title Administrator Date 5/1/17



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Division of Long Term Care
Residents Protection

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3 Mill Road, Suite 308
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(302) 577-6661

STATE SURVEY REPORT

Page 18 of 46

NAME OF FACILITY: Country Rest Home

DATE SURVEY COMPLETED: February 3, 2017

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	<p>pain it will be documented on the MAR, the number of their pain both before and after pain med is given.</p> <p>Review of R3's clinical records revealed:</p> <p>9/19/16 – Admission to facility with physicians' order for Tylenol Arthritis 1300 mg every 8 hours PRN for pain. Not to exceed 4 grams Tylenol in 24 hours.</p> <p>10/16/16 - Physicians' orders included Tylenol 650 mg every 4 hours PRN for pain.</p> <p>11/10/16 – Physicians' orders included Tylenol Arthritis 1300 mg every morning (6am) routine for pain.</p> <p>12/6/16 – Care plan for pain included multiple goals including that R3 will have pain managed to a tolerable level of as evidenced by pain rating of 0 - 2 on a scale of 1 to 10; and resident will verbalize comfort after 1 hour of implementation of alleviating factors. Interventions included: administer medications promptly as ordered by physician, monitoring for effectiveness and increase dosage as needed; and on-going assessment of the resident's pain with emphasis on the onset, location, description, intensity of pain and alleviating and aggravating factors.</p> <p>Review of September, 2016 through January 2017 MARs and nursing notes discovered:</p> <ul style="list-style-type: none"> - 14 out of 17 missing pain severity rating before PRN pain medication (September 25; October 7 and 16; November 2, 6, 7, 10, 19 and 20; January 27 [2 doses], 28 and 29 [2 doses]). - 15 out of 17 missing pain severity rating after PRN pain medication to determine the effectiveness of the medication (September 25; October 7 and 16; November 2, 6, 7, 10, 19 and 20; January 27 (2 doses), 28, 29 (2 doses) and 31). - 11 out of 17 missing pre assessment of location (October 7 and 16; November 7, 10, 19 and 20; January 27 (2 doses), 28, 29 and 31). 	<p>that our policy includes the pain scales used and are listed within the EMR for selection that can work best for individual resident. The DON has also reviewed with the nursing staff that prior to all prn medications, pain meds, the nurse must document in the EMR the comfort measures provided and the scale used for assessment of the resident's pain selected. The nursing staff have been re-educated and reviewed with the importance of pain re-assessment for effectiveness, though the nurse do this, there was no documentation for effectiveness as many of the staff stated they did not know how to select the correct protocol for reminder to document their re-assessments after pain medication was given. The DON is teaching/showing all nursing staff how this system works within the EMR and to select this protocol for all prn medications given. This corrective action will prompt the nursing staff after administering a prn pain medication to re-assess the resident for documentation of effectiveness using the pain scale selected. The DON will review and monitor weekly, the use of the protocol and the documentation completed. Note: The DON had started implementing EMR training prior to survey for better use and understanding of the features available for more accurate documentation.</p>	<p>4/01/2017</p>

Provider's Signature Maik Yoder, Jr. Title Administrator Date 5/1/17



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AND SOCIAL SERVICES**

Division of Long Term Care
Residents Protection

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

STATE SURVEY REPORT

Page 19 of 46

NAME OF FACILITY: Country Rest Home

DATE SURVEY COMPLETED: February 3, 2017

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
---------	--	---	--------------------

	<p>During an interview with E4 (DON) on 2/1/17 at 2:30 PM to review the assessment expectation with the administration of PRN medications E4 said the pain score rating before and after, along with the location of pain and any non-medication interventions attempted should be assessed. When the PRN pain medication order gets entered in the computer eMAR, the protocol must be selected so the computer will automatically prompt the nurse with notification for reassessment allowing the nurse to select reassessment time in 30 or 60 minutes. E4 said "I think 60 minutes is good for pain medications" to determine effectiveness. The DON added that eMAR should ask for pain score rating before and after the PRN medication as well as the location, even if the protocol is not selected. If the resident's pain location is not a choice on the list, the nurse can pick other and type in the comments section. When the surveyor reviewed the missing assessments, E4 said "You saw what I saw" and proceeded to show the surveyor an email that the DON sent to all nurses on 1/11/17 – "anytime a prn medication is given there must be a note in the chart documenting the resident behavior or symptom, what was done prior to giving the medication ... This is so important when administering.... pain medications, fever or headache or other prn medications"</p> <p>2. Review of R7's clinical records revealed:</p> <p>The facility's policy for No stock of Medication's objective is to ensure that residents are given their prescribed medication in a timely manner per state regulation. Procedures included; if the family or hospice is unable to get the medications to the facility without missing a dose, then the medication should be supplied by our pharmacy until the primary source has arrived.</p> <p>R7 had a physician's order originating 8/3/16 for</p>	<p>F309 As part of our QAPI plan the DON will monitor daily residents EMR for prn medication administration, for accurate document of pain pre-assessment scale used and post effectiveness documentation, and scale used for measurability. The DON will continue to educate and review with nursing staff the use of the prn medication protocol for ease of documentation and reminder to re-assess the resident.</p> <p>2. The DON has reviewed with our Hospice providers how the issue/ordering of residents medications can be more effective. The Hospice Director assured me that from now on the nursing staff is to call them directly when there are medications needed for a resident that Hospice provides. This and the fact that the DON has had Hospice to come in for an in-service with our staff on how to better communicate with them and each other for improved medication procurement. Cont.....</p>	<p>4/06/2017</p> <p>4/07/2017</p>
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AND SOCIAL SERVICES**

Division of Long Term Care
Residents Protection

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

STATE SURVEY REPORT

Page 20 of 46

NAME OF FACILITY: Country Rest Home

DATE SURVEY COMPLETED: February 3, 2017

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	<p>Pramipexole (Mirapex) 0.125 mg three times a day for Parkinson's disease</p> <p>Review of the December 2016 MAR revealed that 16 doses were not available due to "no stock": 12/1 x2, 12/5 x1, 12/10 x3, 12/11 x3, 12/12 x3, 12/17 x2, 12/21 x1, and 12/26 x1.</p> <p>Review of the January 2017 MAR revealed that 9 doses were not available due to "no stock": 1/10 x1, 1/14 x1, 1/19 x1, 1/24 x3, 1/25 x3.</p> <p>During an interview on 2/2/17 at 2:55 PM E4 (DON) revealed R7 missed the doses of medication because Hospice was providing the medications for 4 days at a time and would not always get the refills to the facility timely.</p> <p>These findings were reviewed with E1 (NHA) and E4 on 2/3/17 at 11:00 AM.</p> <p>F314 §483.25(b) Skin Integrity §483.25 (b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that— (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.</p> <p>This requirement is not met:</p> <p>Based on observation, record reviews and</p>	<p>...continued from page 20. See attachment 1-F for staff attendance. The DON reviewed with the nursing staff to call when there are missing medications, Hospice, DON and the Provider, should there be a missed dose. The improved communication with our nursing staff and Hospice in-service for questions and concerns will help ensure our residents are provided with medications in a timely manner for administration and not missing doses. The DON will monitor for any lack of medication daily to immediately obtain via Hospice or the pharmacy to prevent missed doses.</p>	<p>4/07/2017</p>

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**DELAWARE HEALTH
AND SOCIAL SERVICES**

Division of Long Term Care
Residents Protection

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

STATE SURVEY REPORT

Page 21 of 46

NAME OF FACILITY: Country Rest Home

DATE SURVEY COMPLETED: February 3, 2017

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
---------	--	---	--------------------

	<p>interviews, it was determined that for one (R9) out of 12 sampled residents, the facility failed to provide the necessary treatment and services to promote healing of a PU. The facility failed to complete a comprehensive assessment of R9's PU upon admission and failed to accurately reassess the PU weekly during the weeks of 12/25/16-12/31/16 and 1/15/17- 1/21/17. The facility was not able to provide evidence of staff training on the use of a wound vac. Findings include:</p> <p>According to the NPUAP Prevention and Treatment of Pressure Ulcers: Quick Reference Guide, dated 2014, PU assessment includes "...Document the results of all wound assessments...With each dressing change, observe the pressure ulcer for signs that indicate a change in treatment is required (e.g., wound improvement, wound deterioration...signs of infection...) Assess and document physical characteristics..."</p> <p>The facility policy, Skin Assessments (last reviewed on 7/20/16), stated, "...All ulcers (types listed) are to go on the skin assessment form in sigma care...This form is to be initiated by the nurse who first finds and treats the wound. The skin integrity form will then be done on a weekly basis on the bath day until the area is healed. ...All ulcers should also have the Ulcer Check Off Sheet completed by the nurse who first assess the wound. ..."</p> <p>Review of R9's clinical records revealed the following:</p> <p>Admission records show that R9 was admitted to the facility on 12/22/16 from a local hospital with a Stage 4 sacral pressure ulcer.</p> <p>No documentation by the facility nursing staff of comprehensive wound assessments R9's EMR or in the hard copy of the chart. The EMR did contain the physician wound care notes that had been scanned into the electronic medical record for visits on 1/3/17, 1/13/17 and 1/26/17.</p>	<p>F314</p> <p>CRH has outside services for pressure wound evaluation and care provided by Millenium. The nursing staff have since been educated that their documentation should include the wound care nurse visits with report regarding wound measurements and the healing process. The DON met with the director of Millenium for improvement of communication and lack of printed reports sent regarding our residents care. This corrective action includes a new communication book with faxed weekly updates on residents being seen stored in this book. The nursing therapy provided is now charted with each visit and added to the book for easy communication. The communication includes wound dressings, wound measurements and healing process. This corrective measure will ensure open communication with the facility staff regarding wound care and timely reports of visits for each resident. The DON is monitoring weekly, the effectiveness of the communication book with the nursing staff for utilization.</p>	<p>3/07/2017</p>
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AND SOCIAL SERVICES**

Division of Long Term Care
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DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

Page 22 of 46

NAME OF FACILITY: Country Rest Home

DATE SURVEY COMPLETED: February 3, 2017

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	<p>The facility failed to complete a comprehensive assessment of his PU upon admission and failed to accurately reassess the PU weekly during the weeks of 12/25/16-12/31/16 and 1/15/17- 1/21/17. A Wound Vac was applied to R9's sacral wound by E21 (a facility LPN) on 1/27/2017 at 4:31 PM per progress notes in the EMR. Since the Wound Vac was applied, the progress notes contained several entries that the facility nurses had to reinforce the Wound Vac dressing due to air leaks.</p> <p>During an interview on 2/1/17 at 3:00 PM E4 (DON) confirmed that aside from the physician notes that had been scanned into the electronic medical record for visits on 1/3/17, 1/13/17 and 1/26/17, there was no other documentation in the clinical record that included comprehensive wound assessments. In addition, E4 confirmed that home care agency nurses were visiting R9 at the facility and providing care to R9's wound since 12/23/16, but that there was no documentation from this agency at the facility. Later, E4 was able to call the agency and have R9's records faxed to the facility. E4 was not able to provide evidence of any staff training on the use of the Wound Vac or care of a resident with a Wound Vac.</p> <p>These findings were reviewed with E1 (NHA) and E4 on 2/03/17 at 11:00 AM during exit conference.</p> <p>F315 §483.25(e) Incontinence. (1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. (2) For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that— (i) A resident who enters the facility without an indwelling catheter is not catheterized</p>	<p>F314 See attachment 1-G The facility has since been given an in-service on the KCL Wound VAC by the company representative. Instruction was given on the wound vac machine and application of dressing as well as monitoring of dressing and warning signals. The DON has developed a new Wound VAC policy that states all nurses must have an wound vac in-service prior to caring for the wound vac resident. The policy includes a visual document for dressing review. This corrective action will ensure the safe and knowledgeable use of the wound vac for our nursing staff. The DON will monitor weekly for review and proper use and adherence to policy guidelines.</p>	<p>3/30/2017</p>

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DELAWARE HEALTH AND SOCIAL SERVICES

Division of Long Term Care
Residents Protection

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

STATE SURVEY REPORT

Page 23 of 46

NAME OF FACILITY: Country Rest Home

DATE SURVEY COMPLETED: February 3, 2017

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
---------	--	---	--------------------

	<p>unless the resident's clinical condition demonstrates that catheterization was necessary;</p> <p><i>(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary and</i></p> <p><i>(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.</i></p> <p><i>(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.</i></p> <p>This requirement is not met: Based on record review and interview it was determined that for two (R8 and R11) out of 12 sampled residents the facility failed to ensure that there was a medical justification for the continued use of an Indwelling Foley catheter. Findings include:</p> <p>The facility's policy for Catheter Associated Urinary Tract Infection (CAUTI) Prevention dated (2012) in the Infection Prevention Manual for Long Term Care documented the following:</p> <ul style="list-style-type: none"> - Catheters should be inserted only when necessary and left in place only as long as needed. - Urinary catheters should not be used for the management of incontinence and consider other methods of urinary drainage. - Do not routinely change indwelling catheters or drainage bags except when clinically indicated, when obstruction occurs, or when the closed system has been compromised. - Bladder irrigation is not recommended unless 	<p>F315 The facility has a revised Foley catheter policy. The revision states that best practice is to discontinue all foley catheters if possible. The revised policy states the acceptable diagnosis for keeping a urinary catheter in place. CRH new MD did collaborate with the DON for the policy revision. Residents with urinary catheters will be assessed for need by the MD, should the MD see no documented need, the catheter will be discontinued and a post catheter voiding trail conducted. The resident that fails the voiding trail will be sent to a Urologist for more evaluation for the need of continued urinary catheter. The DON will take a full history on any new resident admitted with a Cont on next page.....</p>	<p>4/5/2017</p>
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Provider's Signature [Signature] Title Administrator Date 5/1/17



DELAWARE HEALTH AND SOCIAL SERVICES

Division of Long Term Care
Residents Protection

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

STATE SURVEY REPORT

NAME OF FACILITY: Country Rest Home

DATE SURVEY COMPLETED: February 3, 2017

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
---------	--	---	--------------------

	<p>obstruction is anticipated. If obstruction is anticipated, use a closed continuous irrigation.</p> <p>- Examples of "Inappropriate" uses of indwelling catheters included; as a substitute for nursing care of the resident or resident with incontinence; as a means of obtaining urine for culture or other diagnostic test when the resident can voluntarily void; for prolonged postoperative duration without appropriate indications....</p> <p>The following was reviewed in R8's clinical record:</p> <p>R8 was admitted to the facility from 9/3 – 9/30/16 for a respite stay and returned again on 11/29/16 for a respite stay that turned into an extended admission to the facility. The resident had an indwelling urinary catheter on admission. The resident had admitting diagnoses which included overactive bladder and was receiving medication to treat this condition. Review of the record lacked evidence of a medical justification for the use of the catheter.</p> <p>12/13/16 – Laboratory report for > 100,000 Proteus with a note that an antibiotic was ordered for 10 days for an UTI.</p> <p>12/26/16 – Physician's order to change indwelling Foley catheter 18F/30 ml balloon every month. This order was renewed on 1/26/17.</p> <p>1/4/17 4:08 AM – Nurse's note that urine obtained via Foley port for urinalysis and culture.</p> <p>1/4/17 10:14 PM -- Nurse's note that resident went out to the hospital via 911 after vomiting and the urinalysis showed possible UTI.</p> <p>1/6/17 -- Laboratory results show >100,000 Proteus. The resident had been in the hospital since 1/4/17.</p> <p>1/12/17 - R8 returned from the hospital stay.</p> <p>1/15 – 1/17/17 – In hospital after becoming unresponsive. Diagnoses included UTI with Proteus.</p>	<p>foley catheter and review this assessment with the Provider for need.</p> <p>R8 has had a successful removal of the urinary catheter since the survey, there was an order in place from her primary for the catheter, however no urologist was seen and the removal was successful. The DON will continue to monitor foley catheter needs weekly with the MD and that our policy guidelines are followed.</p>	
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Provider's Signature [Signature] Title Administrator Date 5/1/17



DELAWARE HEALTH AND SOCIAL SERVICES

Division of Long Term Care
Residents Protection

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

STATE SURVEY REPORT

Page 25 of 46

NAME OF FACILITY: Country Rest Home

DATE SURVEY COMPLETED: February 3, 2017

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
---------	--	---	--------------------

	<p>1/31/17 – U/A C&S obtained</p> <p>2/2/17 – Laboratory results for > 100,000 Pseudomonas and an antibiotic was ordered for 10 days.</p> <p>During an interview on 2/2/17 at 2:55 PM with E4 (DON) a medical justification was requested for the use of the urinary catheter. A follow-up interview shortly thereafter revealed that there was no further information regarding the use of the catheter other than the father and the doctor would like it left in.</p> <p>2. Review of R11's clinical record revealed: R11 was admitted to the facility on 12/31/16 with an indwelling urinary catheter. Review of the paper and EMR lacked evidence of a physician's order for the catheter on admission. The following was reviewed in the clinical record:</p> <p>1/11/17 – Physician's order to change the catheter monthly. There was no size of catheter noted in the order nor was there any medical justification noted for its use.</p> <p>1/11/17 10:11 PM Progress note - Spoke with resident this evening regarding indwelling catheter, resident states that he has had it for "a long time" and that his doctor says he cannot discontinue it because he has damage to his bladder and will not urinate properly without it.</p> <p>1/30/17 3:37 PM Progress note - Indwelling catheter changed. Tolerated well, when old catheter was removed blood noted coming out from penis inserted an 18 fr (French) cath blood in tubing resident denies any pain or ill effects.</p> <p>1/30/17 6:02 PM Progress note - ...resident stated that his pants felt wet and when he sat down on the toilet he noticed blood in his brief. (Names of staff) were both called to assist. Resident was assisted back to bed. Foley was assessed and flushed, yellow urine was</p>	<p>2. R11 was admitted with a urinary foley catheter in place. The DON did speak with the family regarding the catheter placement and need. Family was very adamant about keeping the catheter in place and that the resident did see a Urologist though not recently. The DON did make an appt with the residents urologist for evaluation and diagnosis for keeping the catheter in place. Since the survey R11 has seen the urologist and a acceptable diagnosis was obtained for the catheters continued need. The newly revised policy for foley catheter use will correct the undocumented diagnosis for catheter placement and continued need. The DON will monitor catheter placement, removal and needed urological evaluation with the MD weekly.</p>	<p>4/5/2017</p>
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Provider's Signature [Signature] Title Administrator Date 5/1/17



**DELAWARE HEALTH
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Division of Long Term Care
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(302) 577-6661

STATE SURVEY REPORT

Page 26 of 46

NAME OF FACILITY: Country Rest Home

DATE SURVEY COMPLETED: February 3, 2017

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
---------	--	---	--------------------

	<p>returned, balloon was checked and found to be filled and intact. Resident reports no pain or discomfort. It was determined that the blood was from possible irritation from Foley being changed earlier in the day...</p> <p>There was no order to flush the urinary catheter found in the clinical record and flushing was not in alignment with the facility policy.</p> <p>1/31/17 7:40 AM Progress note - Resident showed no s/s of pain or discomfort. Resident still continues with blood from and around his catheter. Will continue to monitor.</p> <p>1/31/17 10:33 AM Progress note - Resident noted with a lot of blood coming from his penis this morning during am care, called Dr. (name) to make him aware, resident still denies pain or ill feelings; Dr. (name) gave new order to make an appt. with resident's urologist. Appt made with Dr. (name) but he will not be available until next week in Milford office Feb 8, 2017 at 930 called residents wife...</p> <p>2/1/17 1:15 PM Progress note – Resident had a large amount of blood in the toilet, blood and a large blood clot in his depends. Resident has had blood in his depends since his Foley change on Monday 1/30/17. Spoke with MD and recommend we send him to hospital.</p> <p>2/1/17 7:11 PM Progress note – Reviewed discharge instructions from (name of hospital) ER and only order is to F/U with urologist in 2 days...</p> <p>During an interview on 2/2/17 at 2:45 PM with E5 (LPN) revealed that the resident came to the facility with the urinary catheter and she was told his bladder no longer worked.</p> <p>During an interview on 2/2/17 at 2:55 PM with E4 (DON) a medical justification was requested for the use of the urinary catheter. A follow-up interview shortly thereafter revealed that there was no further information regarding the use of the catheter.</p>		
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Provider's Signature Michael J. [Signature] Title Administrator Date 5/1/17



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3 Mill Road, Suite 308
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(302) 577-6661

STATE SURVEY REPORT

Page 27 of 46

NAME OF FACILITY: Country Rest Home

DATE SURVEY COMPLETED: February 3, 2017

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
---------	--	---	--------------------

	<p>These findings were review with E1 (NHA) and E4 on 2/3/17 at 11:00 AM</p> <p>F329 §483.45(d) Unnecessary Drugs—General. Each resident’s drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used— (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. §483.45(e) Psychotropic Drugs. [§483.45(e)(1)-(5) will be implemented beginning November 28, 2017 (Phase 2)] Based on a comprehensive assessment of a resident, the facility must ensure that--- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; (3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and (4) PRN orders for psychotropic drugs are</p>		
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Division of Long Term Care
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3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

Page 28 of 46

NAME OF FACILITY: Country Rest Home

DATE SURVEY COMPLETED: February 3, 2017

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	<p><i>limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.</i></p> <p>(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.</p> <p>This requirement is not met:</p> <p>Based on record review and interview it was determined that the facility failed to reassess the resident after PRN medication administration for anxiety for 1 (R3) out of 12 sampled residents. Findings include: Undated policy entitled <i>Psychoactive Medication Use</i> (last reviewed by DON 7/16/16) included the following procedure: - psychoactive medication may be initiated after all other interventions have been attempted and exhausted for the resident's safety, safety of others or the well-being of the resident for their highest level of well-being.All attempts must be documented as well as outcomes. - resident must be care planned for the behaviors, goals, interventions, outcomes and side effects.</p> <p>Review of R3's clinical records revealed: 9/19/16 – Admission to the facility with physicians' orders including: - Alprazolam 0.5 mg three times a day (routine) for anxiety. - Alprazolam 0.5 mg four times a day PRN for anxiety.</p> <p>12/5/16 – Care plan problem for anxiety as evidenced by history prior to admission, restlessness related to confusion and new</p>	<p>F329 The facility policy and Care Plan do provide information for anxiety treatment and effective or non-effective redirection and evaluation for need of medication. The DON position is in transition from previous DON and has noted the need for medication evaluation, reduction and documentation for effectiveness. The facility has also changed to a new MD for closer evaluation and more frequent visits/assessment of our residents. Corrective action has been implemented to educate and review with the nursing staff the protocol within the EMR for prn medication and how this is implemented with every prn medication for evaluation of effectiveness. Care Plans have recently been incorporated into the EMR from paper. The nursing staff are learning to use, update and review CP's using the EMR system. The DON continues to monitor progress of Cont....on next page.</p>	<p>03/30/2017</p>

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Division of Long Term Care
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3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

Page 29 of 46

NAME OF FACILITY: Country Rest Home

DATE SURVEY COMPLETED: February 3, 2017

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
---------	--	---	--------------------

	<p>environment included goals: Any episodes of anxiety will be resolved within 60 minutes, will decrease; and will be quickly resolved by 90 days. Interventions included attempt to offer positive reinforcement; to redirect when anxious; to refocus thought processes when appearing anxious; to validate feelings when anxious. Encourage in room visits and good staff interaction. Encourage resident participation in decision making concerning timing of care, clothes to wear and activities to attend. If resident is coherent enough encourage to talk about what is causing anxiety and assist in problem solving. Keep in low stimulated environment. Keep physician informed of anxiety episodes, including specific behaviors and triggers. Keep physician informed of effectiveness of medications. Monitor for possible side effects to medications.</p> <p>12/30/16 – Physicians' order reduced the previous Alprazolam PRN order from four times a day to once daily PRN for anxiety.</p> <p>Review of September, 2016 through January 2017 MARs and nursing notes discovered 8 (eight) administrations out of 23 with no post assessment (September 23, 24, 25, and 30; October 1, 13 and 21; November 6).</p> <p>During an interview with E4 (DON) on 2/1/17 at 2:30 PM to review assessments for PRN anxiety medication E4 said besides the behavior monitoring sheet matching the PRN administrations on the eMAR, the nurse needs to write a note about the specific behaviors and whether redirection was effective. Surveyor showed missing assessments after anxiety medications and that nursing notes did not address. E4's response was "So you saw what I saw." The DON provided a copy of an email sent to all nurses on 1/11/17 about the need to write a note in the chart describing resident behavior/symptom, what was done prior to the PRN medication.</p> <p>These findings were reviewed with E1 (NHA) and</p>	<p>nursing staff daily on implementation of protocol for prn medications and the documented effectiveness of medication administered. The DON continues to monitor EMR selection by viewing residents prn medication effectiveness via documentation within the system daily. Nursing staff have reminders sent out via message system within the EMR for continued review. The staff are now able to view goals and interventions of care plans within the EMR for ease of use. These corrective measures, including new MD, will ensure timely medication review/evaluation, protocol and care plan use with continued monitoring weekly for compliance.</p>	<p>4/7/2017</p>
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**DELAWARE HEALTH
AND SOCIAL SERVICES**

Division of Long Term Care
Residents Protection

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

STATE SURVEY REPORT

Page 30 of 46

NAME OF FACILITY: Country Rest Home

DATE SURVEY COMPLETED: February 3, 2017

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
---------	--	---	--------------------

	<p>E4 on 2/3/17 at 11:00 AM.</p> <p>F334 §483.80 Infection Control §483.80(d) Influenza and pneumococcal immunizations</p> <p>(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.</p> <p>(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal</p>		
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DELAWARE HEALTH AND SOCIAL SERVICES

Division of Long Term Care
Residents Protection

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

STATE SURVEY REPORT

Page 31 of 46

NAME OF FACILITY: Country Rest Home

DATE SURVEY COMPLETED: February 3, 2017

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
---------	--	---	-----------------

	<p>immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii)The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This requirement is not met:</p> <p>Based on record review and interview it was determined that the facility failed to offer a current flu and pneumococcal vaccine to one (R9) out of 6 sampled residents.</p> <p>Record review revealed that R9 had moved into the facility on 12/22/2016, and had not been offered a flu or pneumonia vaccine. During an interview at 12:45 on 2/2/17 E4 (DON) confirmed these findings. Findings were reviewed with E1 (NHA) and E4 at 10:55 AM on 2/3/17.</p> <p>F441 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. (a) Infection prevention and control program. The facility must establish an infection</p>	<p>F334 See attachment 1-H New updated consent forms for immunization have since been implemented by the DON The facility has implemented a new 'immunization record' to monitor immunization dates given, refusal of, etc. within the EMR system for each resident. This corrective action will help monitor immunizations given or missing. R9 first came to us a respite and then transitioned to resident weeks later. The family, at that time was given/reviewed with admission forms including immunization consent forms. The DON can monitor immunization monthly, by scanned consent forms in the EMR and the immunization record as updated. This corrective action will help keep a more efficient/updated immunizations record.</p>	<p>3/15/2017</p>
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Division of Long Term Care
Residents Protection

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

STATE SURVEY REPORT

Page 32 of 46

NAME OF FACILITY: Country Rest Home

DATE SURVEY COMPLETED: February 3, 2017

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
---------	--	---	--------------------

	<p><i>prevention and control program (IPCP) that must include, at a minimum, the following elements:</i></p> <p><i>(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;</i> <i>[As linked to Facility Assessment, §483.70(e), will be implemented beginning November 28, 2017 (Phase 2)]</i></p> <p><i>(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</i></p> <p><i>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</i></p> <p><i>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</i></p> <p><i>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</i></p> <p><i>(iv) When and how isolation should be used for a resident; including but not limited to:</i></p> <p><i>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</i></p> <p><i>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</i></p> <p><i>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin</i></p>		
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**DELAWARE HEALTH
AND SOCIAL SERVICES**

Division of Long Term Care
Residents Protection

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

STATE SURVEY REPORT

Page 33 of 46

NAME OF FACILITY: Country Rest Home

DATE SURVEY COMPLETED: February 3, 2017

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
---------	--	---	--------------------

	<p>lesions from direct contact with residents or their food, if direct contact will transmit the disease; and</p> <p><i>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.</i></p> <p><i>(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use.</i></p> <p><i>[\$483.80(a)(3) will be implemented beginning November 28, 2017 (Phase 2)]</i></p> <p><i>(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</i></p> <p><i>§483.80 (b) Infection preventionist</i></p> <p><i>[\$483.80(b) and all subparts will be implemented beginning November 28, 2019 (Phase 3)]</i></p> <p><i>The facility must designate one or more individual(s) as the infection preventionist(s) (IP)(s) who is responsible for the facility's IPCP. The IP must:</i></p> <p><i>(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field;</i></p> <p><i>(2) Is qualified by education, training, experience or certification;</i></p> <p><i>(3) Works at least part-time at the facility; and</i></p> <p><i>(4) Has completed specialized training in infection prevention and control.</i></p> <p><i>§483.80 (c) IP participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis.</i></p> <p><i>[\$483.95(c) will be implemented beginning November 28, 2019 (Phase 3)]</i></p>		
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DELAWARE HEALTH AND SOCIAL SERVICES

Division of Long Term Care
Residents Protection

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

STATE SURVEY REPORT

Page 34 of 46

NAME OF FACILITY: Country Rest Home

DATE SURVEY COMPLETED: February 3, 2017

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
---------	--	---	-----------------

	<p><i>(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</i></p> <p><i>(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.</i></p> <p><i>This requirement is not met:</i></p> <p>Based on record review, observation and interview it was determined that the facility failed to establish and maintain an Infection Control Program to help prevent the development and transmission of disease and infection by failing to perform a second round of PPD testing for 8 (E6, E14, E15, E16, E17, E18, E19 and E20) out of 11 sampled employees and 1 (R2) out of 6 sampled residents. Additionally the facility failed to provide a room under negative pressure for receiving, sorting and washing soiled linen and a room under positive air pressure for drying and folding clean linen. Findings include:</p> <p>1. Observation at 10:00 AM on 2/1/17 with E22 (Laundry) revealed three rooms used for laundry; a washing room, drying room, and folding room. The door between the washing and drying room was open, and there was an open window in the drying room. There was also a lack of positive pressure (no vents in this room) in the drying room. E22 explained that the door between the rooms is always open, as well as a window in the drying room.</p> <p>An observation on 2/2/17 at 11:05 PM with E12 (FMD) revealed the door between the washing and drying room was open and the window in the drying room was open. The drying and folding rooms are not under positive pressure.</p> <p>To prevent the transmission of infectious organisms, the rooms used for sorting and washing must be under negative pressure, the rooms used for drying and folding must be under positive pressure, and all doors must remain closed.</p>	<p>F441 CRH has implemented the 2 step PPD requirement for all new employees that have no history of allergies to vaccine. The administrative assistant will review all new employee files to ensure that a 2 step PPD was done on hire.</p> <p>F441 The facility laundry rooms are being updated to include positive pressure air flow above the dryer and laundry folding area for decreased entry of infectious organisms. The soiled laundry room is being updated with better working negative pressure air out take to prevent transmission of infectious organism. The door between the dryer and wash room has been closed and the rationale explained to the laundry staff. The window in the dryer room has been closed to maintain positive pressure. The laundry department updates/recommendations will be completed in a timely manner. This corrective action will comply with the state guidelines for infection control. The laundry supervisor will train and monitor daily that the door between the dryer room and the</p>	<p>3/01/2017</p> <p>04/07/2017</p>
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Provider's Signature *Maria Lopez* Title Administrator Date 5/1/17



DELAWARE HEALTH AND SOCIAL SERVICES

Division of Long Term Care
Residents Protection

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

STATE SURVEY REPORT

Page 35 of 46

NAME OF FACILITY: Country Rest Home

DATE SURVEY COMPLETED: February 3, 2017

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
---------	--	---	--------------------

	<p>During an interview at 12:45 on 2/2/17 E4 (DON) confirmed these findings.</p> <p>2. Record review of the completed Personnel Audit Sheet, received by surveyors at 4:05 PM on 2/1/17 revealed a second step PPD test was not performed on E6, E14, E15, E16, E17, E18, E19 and E20.</p> <p>3. Record review revealed that a second step PPD test was not performed on R2.</p> <p>Findings were reviewed with E1 (NHA) and E4 at 10:55 AM on 2/3/17.</p> <p>F463 F463 §483.90(f) Resident Call System <i>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—</i> (1) Each resident's bedside; and [483.90(f)(1) will be implemented beginning November 28, 2019 (Phase 3)]</p> <p>(2) Toilet and bathing facilities.</p> <p>This requirement is not met;</p> <p>Findings include: Based on observation and interview the facility failed to be equipped with a resident call system which meets the current standards of the Guidelines for Design and Construction of Health Care Facilities on one (old unit) out of two units. An anonymous complaint was filed by a resident's family member concerned with the lack of a modern resident call system. During an interview on 2/2/17 at 2:08 PM, the complainant also expressed concern that the hand bells are not always kept in reach of the residents.</p>	<p>Wash room is kept closed at all times. Maintenance will monitor monthly that the positive and negative air flow is in proper working order.</p> <p>F463 Since the survey CRH has contacted, North East Protection Partners, who will be installing and training our staff for the new wireless system to be installed beginning 4/24/2017. This installation will be for the hall that was using the hand bell call system. Administration will monitor daily the training with staff, with continued monitoring monthly for maintenance needs, to keep the system in good working order.</p>	<p>4/07/2017</p>
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Provider's Signature Maria Yoder Title Administrator Date 5/1/17



**DELAWARE HEALTH
AND SOCIAL SERVICES**

Division of Long Term Care
Residents Protection

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

STATE SURVEY REPORT

Page 36 of 46

NAME OF FACILITY: Country Rest Home

DATE SURVEY COMPLETED: February 3, 2017

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
---------	--	---	--------------------

	<p>Observations throughout the survey 1/31/17 8:40 AM through 2/2/17 4:00 PM revealed that the old unit uses hand bells in the resident bedrooms and bathrooms. This call system does not activate a visual signal in the corridor at the resident's door or a mobile device carried by a staff member. Findings were reviewed and confirmed with E4 (DON) on 2/2/17 at 2:15 PM. Findings were reviewed with E1 (NHA) and E4 at 10:55 AM on 2/3/17.</p> <p>F520 <i>§483.75 Quality assurance and performance improvement.</i> <i>[§483.75 and all subparts will be implemented beginning November 28, 2019 (Phase 3), unless otherwise specified]</i> <i>§483.75(a) Quality assurance and performance improvement (QAPI) program. Each LTC facility, including a facility that is part of a multiunit chain, must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility must:</i> <i>(1) Maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities;</i> <i>(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation;</i> <i>[§483.75(a)(2) will be implemented beginning November 28, 2017 (Phase 2)]</i></p>	<p>F463 The new wireless call bell system will include the residents' bathrooms and have a visual 'light' signal as well. To be installed starting 4/24/2017.</p>	<p>4/07/2017</p>
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**DELAWARE HEALTH
AND SOCIAL SERVICES**

Division of Long Term Care
Residents Protection

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

STATE SURVEY REPORT

Page 37 of 46

NAME OF FACILITY: Country Rest Home

DATE SURVEY COMPLETED: February 3, 2017

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
---------	--	---	--------------------

	<p><i>(3) Present its QAPI plan to a State Survey Agency or Federal surveyor at each annual recertification survey and upon request during any other survey and to CMS upon request; and</i></p> <p><i>(4) Present documentation and evidence of its ongoing QAPI program's implementation and the facility's compliance with requirements to a State Survey Agency, Federal surveyor or CMS upon request.</i></p> <p><i>§483.75(b) Program design and scope. A facility must design its QAPI program to be ongoing, comprehensive, and to address the full range of care and services provided by the facility. It must:</i></p> <p><i>(1) Address all systems of care and management practices;</i></p> <p><i>(2) Include clinical care, quality of life, and resident choice;</i></p> <p><i>(3) Utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents of a SNF or NF.</i></p> <p><i>(4) Reflect the complexities, unique care, and services that the facility provides.</i></p> <p>91</p> <p><i>§483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following:</i></p> <p><i>(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems</i></p>		
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**DELAWARE HEALTH
AND SOCIAL SERVICES**

Division of Long Term Care
Residents Protection

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

STATE SURVEY REPORT

Page 38 of 46

NAME OF FACILITY: Country Rest Home

DATE SURVEY COMPLETED: February 3, 2017

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
---------	--	---	--------------------

	<p><i>that are high risk, high volume, or problem-prone, and opportunities for improvement.</i></p> <p><i>(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators.</i></p> <p><i>(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.</i></p> <p><i>(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.</i></p> <p><i>§483.75 (d) Program systematic analysis and systemic action. (§483.75 (d) will be implemented during Phase 3)</i></p> <p><i>(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.</i></p> <p><i>(2) The facility will develop and implement policies addressing:</i></p> <p><i>(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;</i></p> <p><i>(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and</i></p> <p><i>(iii) How the facility will monitor the effectiveness of its performance improvement</i></p>		
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Provider's Signature Mark Johnson Title Administrator Date 5/1/17



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Division of Long Term Care
Residents Protection

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

STATE SURVEY REPORT

Page 39 of 46

NAME OF FACILITY: Country Rest Home

DATE SURVEY COMPLETED: February 3, 2017

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
---------	--	---	--------------------

	<p><i>activities to ensure that improvements are sustained.</i></p> <p>§483.75(e) Program activities. 92</p> <p><i>(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.</i></p> <p><i>(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.</i></p> <p><i>(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section</i></p> <p>§483.75(f) Governance and leadership. <i>The governing body and/or executive leadership (or organized group or individual who assumes full legal authority and responsibility for operation of the facility) is responsible and accountable for ensuring that:</i></p> <p><i>(1) An ongoing QAPI program is defined, implemented, and maintained and addresses identified priorities.</i></p> <p><i>(2) The QAPI program is sustained during</i></p>		
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Provider's Signature *Marcel Jacoby Jr.* Title Administrator Date 5/1/17



**DELAWARE HEALTH
AND SOCIAL SERVICES**

Division of Long Term Care
Residents Protection

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

STATE SURVEY REPORT

Page 40 of 46

NAME OF FACILITY: Country Rest Home

DATE SURVEY COMPLETED: February 3, 2017

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	<p><i>transitions in leadership and staffing;</i> <i>(3) The QAPI program is adequately resourced, including ensuring staff time, equipment, and technical training as needed;</i> <i>(4) The QAPI program identifies and prioritizes problems and opportunities that reflect organizational process, functions, and services provided to residents based on performance indicator data, and resident and staff input, and other information.</i> <i>(5) Corrective actions address gaps in systems, and are evaluated for effectiveness; and</i> <i>(6) Clear expectations are set around safety, quality, rights, choice, and respect.</i></p> <p>This requirement is not met:</p> <p>Based on interview and review of facility documentation, it was determined that the facility's Quality Assurance (QAA) committee failed to have evidence that the Medical Director attended the QAA quarterly meetings. Findings include:</p> <p>Review of the facility's quarterly QAA committee sign-in sheets from all of calendar year 2016 lacked evidence of the presence of the Medical Director (E10) at half of the four quarterly QAA meetings. E10 attended QAA meetings on February 26, 2016 and on May 27, 2016; however, he did not attend the August 26, 2016 or the December 30, 2016 meeting.</p> <p>During an interview on 2/02/17 at 10:00 AM with E4 (DON) it was confirmed that the facility was unable to provide documentation that the Medical Director was in attendance for two of the quarterly meetings.</p> <p>These findings were reviewed with E1 (NHA) and E4 (DON) on 2/03/17 at 11:00 AM during exit conference.</p> <p>State Only 4.0 Licensing Requirements and Procedure</p>	<p>F520 During the survey, CRH was in transition from one MD to our new MD through PAPP. Our new MD started with CRH as of 4/01/2017. The MD has already accepted with plans to attend our next QA meeting scheduled for 4/21/2017. The previous MD rarely was able to attend the QA meetings? The last QA meeting the previous MD was out sick and unable to attend. The new MD has assured me of the importance of his attendance to the QA meetings that have been scheduled for the year of 2017. The requirement has been corrected with the hiring of a new MD with PAPP. The DON will monitor attendance quarterly.</p>	<p>4/01/2017</p>

Provider's Signature Wanda J. Jones, Jr. Title Administrator Date 5/1/17



DELAWARE HEALTH AND SOCIAL SERVICES

Division of Long Term Care
Residents Protection

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

STATE SURVEY REPORT

Page 41 of 46

NAME OF FACILITY: Country Rest Home

DATE SURVEY COMPLETED: February 3, 2017

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
---------	--	---	--------------------

	<p>4.9 When a facility plans to construct or extensively remodel a licensed facility or convert a building to a licensed facility, it shall submit one copy of properly prepared plans and specifications for the entire facility to the Division. An approval, in writing, shall be obtained before such work is begun. After the work is completed, in accordance with the plans and specifications, a modified license to operate shall be issued. All completed construction, extensive remodeling or conversions shall remain in accordance with the plans and specifications, as approved by the Division.</p> <p>This requirement is not met:</p> <p>Based on observation and interview it has been determined that the facility failed to submit remodeling and construction plans and specifications to the Division of Residents Protection for approval. Findings include: Observations were made on 1/31/16 around 12:00 PM of the newly remodeled area, noting a new office and larger living area. An interview at the same time with E2 (Administrative Assistant) confirmed that the front of the old unit was extended several feet, expanding the living area, changing the location of the front door, adding an office, moving the access to the stairwell. A new wheel chair ramp was added to the front of the building along with a tile bathroom on the old unit. During an interview at 2:05 PM on 2/1/17 E1 (NHA) mentioned that construction was done in the ceiling and most walls in this reconstructed area of the old unit. Findings were reviewed with E1 (NHA) and E4 (DON) at 10:55 AM on 2/3/17.</p>	<p>4.9 I am sorry that we failed to notify you of the remodeling and construction plans. I did secure building permits from the county office and the State Fire Marshall's office and we had plans drawn up by a licensed engineer. I am not sure why we didn't think about contacting your office. My apologies and I will be sure that we notify you in the future of any construction that we plan to do.</p>	
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Provider's Signature Mark J. Jody Title Administrator Date 5/1/17



**DELAWARE HEALTH
AND SOCIAL SERVICES**

Division of Long Term Care
Residents Protection

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

STATE SURVEY REPORT

Page 42 of 46

NAME OF FACILITY: Country Rest Home

DATE SURVEY COMPLETED: February 3, 2017

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
---------	--	---	--------------------

	<p>5.6 Dementia Training 5.6.1 Nursing facilities that provide direct healthcare services to persons diagnosed as having Alzheimer's disease or other forms of dementia shall provide dementia specific training each year to those healthcare providers who must participate in continuing education programs. This section shall not apply to persons certified to practice medicine under the Medical Practice Act, Chapter 17 of Title 24 of the Delaware Code. This requirement was not met:</p> <p>Based on record review it was determined that the facility failed to provide dementia specific training to one (E13) out of 7 sampled healthcare providers within the past year. Findings include: Review of the completed Dementia Training form, returned to the surveyors on 2/2/17 at 11:00 AM revealed that E13 (LPN) last completed dementia training on 8/14/15. Findings were reviewed with E1 (NHA) and E4 (DON) at 10:55 AM on 2/3/17.</p> <p>6.4 Services to Residents 6.4.2 All written or verbal physician orders shall be signed by the attending physician or prescriber within 10 days. This requirement was not met: Based on record review and interview it was determined that the facility failed to ensure physicians' orders were signed off in ten days for three (R4, R9 and R10) out of 12 sampled residents. Findings include:</p> <p>1. Review of R4's clinical records revealed the following physicians' orders were not signed in 10 days: - 1/18/17: Chem 7 (lab test) in 4 weeks – not signed off as of 2/2/17 (14 days). - 12/21/16: Chem 7 in 4 weeks – signed by MD 1/9/17</p>	<p>5.6.1 All staff with direct resident care will have Dementia training upon hire and annually thereafter. Administration and the DON, will monitor this specific training for compliance prior to each license renewal and evaluation dates annually. The staff is required to give Administration documentation of completed training annually.</p> <p>6.4.2 The facility has corrected the issue with orders not being signed off by the physician in the time frame allowed. The previous MD has been replaced with a new MD and NP's with the physician provided through PAPP. The new MD has many years experience in LTC and has no other practices to govern other than LTC facilities. This action or change will be monitored by the DON and Administration weekly, that all is being completed within the time frame allowed. The DON feels confident this requirement will be met in the future.</p>	<p>3/01/2017</p> <p>4/01/2017</p>
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Provider's Signature Marcus J. Porter, Jr. Title Administrator Date 5/1/17



DELAWARE HEALTH AND SOCIAL SERVICES

Division of Long Term Care
Residents Protection

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

STATE SURVEY REPORT

Page 43 of 46

NAME OF FACILITY: Country Rest Home

DATE SURVEY COMPLETED: February 3, 2017

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
---------	--	---	--------------------

	<p>(19 days) - 12/21/16: Encourage fluids - signed by MD 1/9/17 (19 days) - 11/5/16: Clean between thumb and forefinger with.... and apply a band-aid - signed off 12/6/16 (31 days).</p> <p>2. Review of R9's current physician orders in the electronic medical record on 2/3/17, the following orders were not signed in 10 days: -1/16/2017: Regular diet -high protein – NAS, Shake ups tid, with meals (15 days) -1/18/17: Right leg immobilizer when out of bed (13 days)</p> <p>3. Review of R10's current physician orders in the electronic medical record on 2/3/17, the following orders were not signed in 10 days: -1/16/2017: Offer HS snack QD (15 days) -1/14/17: pressure areas between 1st and 2nd digits to both feet, clean with NSS, apply TAO, cover with DSD, change daily and PRN (17 days/</p> <p>During an interview with E4 (DON) on 2/2/17 at 12:50 PM when reviewing the delay in the physician signing off orders, E4 stated E10 (Physician) "is slow in doing things" and that the orders stay in pending status until the doctor comes in to sign them. E10 signs orders in batches. I want to meet with E10 to let him know my expectations and offer to teach him how to document in the computer.</p> <p>These findings were reviewed with E1 (NHA) and E4 on 2/3/17 at 11:00 AM.</p> <p>6.8 Medications 6.8.1 Medication Administration 6.8.1.1 All medications (prescription and over-the-counter) shall be administered to residents in accordance with orders which are signed and dated by the ordering physician or prescriber. Each medication shall have a documented supporting diagnosis. Verbal or telephone orders shall be written by the nurse receiving the order and then signed by</p>	<p>2 & 3. The previous MD has come in the facility and finished much of the work that was left. Physician orders have been signed off, making ready for the new MD. The previous MD was ready to move on as the demanding needs of his practice were preventing him from performing the duties of MD for CRH. This change/corrective action taken by Administration was needed and will prevent overdue pending status of orders in the future. The DON will continue to monitor weekly that the physician orders are being signed off in a timely manner.</p>	<p>4/01/2017</p>
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Provider's Signature Mark A. [Signature] Title Administrator Date 5/1/17



DELAWARE HEALTH AND SOCIAL SERVICES

Division of Long Term Care
Residents Protection

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

STATE SURVEY REPORT

NAME OF FACILITY: Country Rest Home

DATE SURVEY COMPLETED: February 3, 2017

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	<p>the ordering physician or prescriber within 10 days.</p> <p>This requirement was not met: Based on record review and interview it was determined that the facility failed to ensure that medication orders were signed off by the physician in ten days for two (R9 and R10) out of 12 sampled residents. Findings include:</p> <p>1. Review of R9's current physician orders in the EMR on 2/3/17, the following medication orders were not signed in 10 days: -1/22/17: Bisacodyl 5 mg tablet, delayed release. give 1 tablet (5 mg) by oral route as one dose for no BM within 3 days and repeat next shift if no results (12 days) -1/12/17: Coreg 3.125 mg tablet. give 1 tablet (3.125 mg) by oral route 2 times per day Hold if SBP less than 100 or HR less than 50 (22 days) -1/14/17: Milk of Magnesia 400 mg/5 mL oral suspension. give 30 milliliters by oral route as needed for no BM in 3 days or nurses judgement for constipation. Repeat next shift if no results (20 days)</p> <p>2. Review of R10's current physician orders in the EMR on 2/3/17, the following medication orders were not signed in 10 days: -1/18/17: Bisacodyl 5 mg tablet delayed release give 1 tablet (5 mg) by oral route as one dose for no BM within 3 days and repeat next shift if no results (16 days) -1/14/17: Lasix 20 mg tablet. give 1 tablet (20 mg) by oral route once daily at noon (20 days)</p> <p>3. Review of R8's EMR revealed the following orders that had not been signed by the physician: - 1/13/16 ASA (Aspirin) 81 mg qd for cerebral infarction (stroke) – pending sign off (21 days) - 1/14/17 APAP (Tylenol) 650 mg prn q4 for pain for temperature – pending sign off (20 days) - 1/17/17 Clonazepam 2 mg bid for seizures – pending sign off (17 days)</p>	<p>6.8.1 As noted previously, many pending orders were overdue; the DON made repeated attempts to have the previous MD to sign off the orders, which was very taxing at best. The DON had offered to meet with the previous MD for more computer training to review and sign off orders from his office/home to help, no meeting ever took place. CRH Administration made an executive decision to seek a new MD via PAPP. The new MD began his services on 4/01/2017. The DON will continue to monitor weekly that physician orders are signed within the 10 days allotted.</p>	<p>4/01/2017</p>

Provider's Signature *Mark Johnson* Title Administrator Date 5/1/17



**DELAWARE HEALTH
AND SOCIAL SERVICES**

Division of Long Term Care
Residents Protection

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

STATE SURVEY REPORT

Page 45 of 46

NAME OF FACILITY: Country Rest Home

DATE SURVEY COMPLETED: February 3, 2017

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	<p>During an interview with E4 (DON) on 2/2/17 at 12:50 PM when reviewing the delay in the physician signing off orders, E4 stated E10 (Physician) "is slow in doing things" and that the orders stay in pending status until the doctor comes in to sign them. E10 signs orders in batches. I want to meet with E10 to let him know my expectations and offer to teach him how to document in the computer.</p> <p>These findings were reviewed with E1 (NHA) and E4 on 2/3/17 at 11:00 AM.</p> <p>7.4 Physical Environment Requirements 7.4.3 Bathrooms 7.4.3.6 Separate bathroom and hand washing sinks shall be provided for the staff. This requirement is not met: Based on observation and interview it was determined that the facility failed to ensure the safety of residents by having staff restrooms accessible to them. Two staff restrooms, which do not include safety devices such as hand rails and call bells, are unlocked in the hallways of the old unit. Findings include:</p> <p>During an initial tour between 2:34 and 3:20 PM on 1/31/17 and a second tour between 9:40 and 10:00 AM on 2/1/17 observations were made of two bathrooms, that open into the corridor on the old unit, with no hand rail next to the toilet nor call bell. During an interview at 11:00 AM on 2/2/17, E12 (FMD) noted that these bathrooms were used only by staff members. During an interview at 2:15 PM on 2/2/17, E4 (DON) stated that the two bathrooms were not meant to be resident bathrooms and agreed that they should not be accessible. Findings were reviewed with E1 (NHA) and E4 at 10:55 AM on 2/3/17.</p> <p>9.0 Records and Reports 9.6 All incident reports whether or not required to be reported shall be retained in facility files for three years. Reportable incidents shall be communicated immediately, which shall be within eight hours of the</p>	<p>7.4 The hallway bathrooms on the old hallways, which are designated for employees, have been made inaccessible to our residents. Locks have been implemented to keep the residents from wandering into employee/staff bathrooms. This correction will resolve the safety concerns for bathroom access precautions. All staff will monitor daily that staff bathroom doors are locked when not in use.</p>	<p>2/22/2017</p>

Provider's Signature [Signature] Title Administrator Date 5/1/17



DELAWARE HEALTH AND SOCIAL SERVICES

Division of Long Term Care
Residents Protection

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

STATE SURVEY REPORT

Page 46 of 46

NAME OF FACILITY: Country Rest Home

DATE SURVEY COMPLETED: February 3, 2017

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	<p>occurrence This requirement is not met:</p> <p>Based on record review, interview, and review of facility documentation, it was determined that for one (R2) out of 12 sampled residents the facility failed to immediately report a reportable incident. Findings include: On 4/30/16, R2 was involved in an incident documented by the facility as an attempted suicide. The incident was reported to the State Agency on 5/2/16, which is greater than the eight hours suggested reporting window of immediacy. During an interview on 2/2/17 at 3:19 PM with E2 (RN), DON at time of incident, it was confirmed that the facility did not immediately report this reportable incident. E2 could not explain why there was a delay in reporting, and confirmed that the facility did not have a system in place to ensure that reportable incidents are reported when management staff was not present. These findings were reviewed with E1 (NHA) and E4 (DON) during exit conference on 2/2/17 at 11:00 AM.</p>	<p>9.0 As previously stated, the facility has taken steps to have all reportable incidents reported to the state within the 8 hour window required. The nursing staff are being educated and trained on how to report state incidents. The nursing staff has been provided the Delaware state LTC incident reporting link for ease of use. The DON has also reviewed with each nurse what reportable incidents are. The nursing staff will still notify the DON or Administration immediately of incidents that require further investigation or immediate action. The DON will monitor state reporting within the guidelines via incident report review of date and time reported daily, should an incident have occurred.</p>	<p>03/30/2017</p>

Provider's Signature

Mark G. Yoder, Jr.

Title Administrator

Date

5/1/17