

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

PRINTED: 04/25/2019
FORM APPROVED
OMB NO. 0938-0391

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|---|---|---|---|----------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085055 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 02/28/2019 |
| NAME OF PROVIDER OR SUPPLIER WESTON SENIOR LIVING CENTER AT HIGHFIELD | | | STREET ADDRESS, CITY, STATE, ZIP CODE 4800 LANCASTER PIKE WILMINGTON, DE 19807 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | |
| E 000 | Initial Comments An unannounced annual and complaint survey was conducted at this facility beginning February 18, 2019 and ending February 25, 2019. The facility census the first day of the survey was 15. An Emergency Preparedness survey was also conducted on March 26, 2019 by the State of Delaware Division of Health Care Quality, Office of Long Term Care Residents Protection in accordance with 42 CFR 483.73. The facility census on March 26, 2019 was 17. | E 000 | | | |
| F 000 | For the Emergency Preparedness survey, no deficiencies were identified. INITIAL COMMENTS An unannounced annual and complaint survey was conducted at this facility from 2/21/19 through 2/28/18. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census the first day of the survey was 15. The survey sample size was 15. Abbreviations /definitions used in this report are as follows: AD - Activities Director; ADON - Assistant Director of Nursing; CEO - Chief Executive Officer; CNA - Certified Nurse's Aide; DON - Director of Nursing; DOR - Director of Rehabilitation; LPN - Licensed Practical Nurse; MD - Medical Doctor; NHA - Nursing Home Administrator; RN - Registered Nurse; RNAC - RN Assessment Coordinator; | F 000 | | | |

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

TITLE

(X6) DATE
03/22/2019

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| F 000 | <p>Continued From page 1</p> <p>IDT - Interdisciplinary Team; professionals from different fields and departments who work together with the resident to develop and implement an individualized plan of care;</p> <p>ADL (Activities of Daily Living) - tasks needed for daily living, e.g. dressing, hygiene, eating, toileting, bathing;</p> <p>B&B - Bowel & Bladder;</p> <p>BR-bath room;</p> <p>CDC - Center for Disease Control;</p> <p>Cognitive - thinking, memory;</p> <p>Clonazepam - (Klonopin) - a medication used to prevent and treat seizures, panic disorder, and for the movement disorder known as akathisia;</p> <p>Contracture - joint with fixed resistance to passive stretch of a muscle and cannot straighten;</p> <p>E.g. - (e.g.) - example;</p> <p>Etc.- (etc) - and so forth;</p> <p>IDT (Interdisciplinary Team) - professionals from different areas work together with the resident to develop and carry out an individualized plan of care;</p> <p>LE's (Lower Extremities) - includes the hip, knee, and ankle joints, and the bones of the thigh, leg, and foot</p> <p>MAR - Medication Administration Record;</p> <p>MDS (Minimum Data Set) Assessment - standardized assessment forms used in nursing homes;</p> <p>Med - medication;</p> <p>Mg (mg) - milligram;</p> <p>P & P - Policy & Procedure;</p> <p>Pneumococcal - pneumonia vaccine;</p> <p>POS - Physician Order Sheet;</p> <p>ROM (Range of Motion) - a measurement of movement around a joint;</p> <p>Stroke - a medical condition caused either by a blood clot stopping blood going through a vessel in the brain or a bleed in the brain;</p> <p>Scheduled (or timed) toileting program - fixed</p> | F 000 | | |

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| F 000 | Continued From page 2 times for toileting assistance to help with urinary incontinence; Tab - tablet; UC (Urinary Continence) - control of bladder function; ability to prevent accidental leakage of urine from bladder UI (Urinary Incontinence) - loss of control of bladder function; UE's (Upper Extremities) - includes the hand, including the arm, axilla and shoulder; Urine - fluid waste formed by the kidney and excreted from the bladder; Voiding Diary - a record of voiding (urinating) for 72 hours and/or 3 days. | F 000 | | | |
| F 585 SS=F | Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution | F 585 | | 4/19/19 | |

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| F 585 | Continued From page 3 of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, | F 585 | | |

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| F 585 | <p>Continued From page 4</p> <p>and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;</p> <p>(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;</p> <p>(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and</p> <p>(vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and review of the facility's policy as indicated, it was determined that the facility failed to ensure a process for residents to file a grievance anonymously. Findings include:</p> <p>Review of the facility's undated policy, entitled Filing Grievance/Complaints, failed to include a process by which residents may file a grievance anonymously.</p> <p>2/25/19 at 11:20 AM - An interview with E5 (AD) confirmed that E5 was not aware of a system by</p> | F 585 | <p>A. Grievance policy reviewed and updated to reflect a process for resident to file a grievance anonymously. No resident was harmed.</p> <p>B. Residents will be educated at monthly resident council meeting of grievance policy and process in which they can file a grievance anonymously. Notice has been posted on all Activity calendar boards to serve as a reminder for all residents to be aware of how to file a grievance/complaint</p> <p>C. Staff will be educated on grievance</p> | |

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| F 585 | Continued From page 5 which residents and family may submit a grievance anonymously. 2/25/19 at 11:43 AM - An interview with E3 (DON) confirmed that the facility did not have a system for residents to submit grievances anonymously, however, will implement a process immediately. 2/28/19 beginning at approximately 4:00 PM - Findings were reviewed with E1 (CEO), E2 (NHA), E3 (DON), and E4 (DOR) during the Exit Conference. | F 585 | policy with emphasis on the process for resident to file anonymously. In the event of a change, either family and/or resident representative will be updated in-person at quarterly Care Conference or a Letter will be sent to Family, POA, etc. in the event of any changes to the Grievance Policy; whichever comes sooner. D. NHA will attend resident council meetings to assure grievance policy and procedure is reviewed with the residents. Administrator or designee will be responsible for recording and maintaining the Resident Grievance Complaint Log. Grievance Complain Log will be reviewed at quarterly QAAP meetings. Completion date 4/19/19 | |
| F 607 SS=E | Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on interview and review of the facility's Abuse Policy and Procedure ("P & P"), it was determined that the facility failed to develop and implement written policies and procedures, which included reporting and investigation of allegations of abuse, neglect, and exploitation of residents | F 607 | A. Abuse policy and procedure reviewed and updated to include reporting and investigation of allegations of abuse, neglect, and exploitation of residents and misappropriation of resident property. No resident was harmed. | 4/19/19 |

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| F 607 | <p>Continued From page 6 and misappropriation of resident property. Findings include:</p> <p>Cross refer F609.</p> <p>1. Review of the facility's undated P & P, entitled "Abuse", revealed the following, related to reporting:</p> <ul style="list-style-type: none"> - Staff members suspecting abuse, neglect or mistreatment must fill out an incident report and write a statement of fact and include any witnesses, if applicable. - The incident must be reported to the DON, ADON, or charge nurse. - If the DON so concludes, then the State is notified of suspected abuse, neglect or mistreatment. <p>The above P & P failed to include reporting requirements for allegations of abuse, neglect, and exploitation of residents and misappropriation of resident property.</p> <p>2/25/19 at approximately 3:00 PM - An interview with E2 (NHA) was held and E2 was advised of the lack of reporting requirements in the above P & P.</p> <p>Cross refer F610.</p> <p>2. Review of the facility's undated P & P, entitled "Abuse", revealed the following related to investigation:</p> <ul style="list-style-type: none"> - Staff members suspecting abuse, neglect or mistreatment must fill out an incident report, write a Statement of Fact and include any witnesses, if applicable. - An internal investigation will occur for the next 72 hours to determine if there is reasonable cause to believe that abuse, mistreatment, or | F 607 | <p>B. Staff will be educated on abuse policy and procedure with emphasis on reporting requirements for allegations of abuse, neglect, and exploitation of residents and misappropriation of resident property. Existing staff will be reeducated and new staff will be educated at orientation of the Abuse Policy with emphasis on situations that would likely be considered crimes include, but are not limited to: Murder, Manslaughter, Rape, Assault & Battery, Sexual Abuse/Assault, Theft/Robbery, Drug diversion for personal use or gain, Identity Theft, Fraud and Forgery.</p> <p>C. Abuse policy reviewed and updated to establish a written process to investigate allegations as well as the results of all investigations are to be forwarded to the administrator or his/her designated representative and to other officials in accordance with State Law, including to the State Survey Agency, within 5 working days of the incident. Any new updates will be reviewed with staff.</p> <p>D. Abuse policy will be reviewed and updated annually with the Quality Assurance team. Completion Date by 4/19/19 using means of mandatory in-servicing for staff.</p> | |

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| F 607 | Continued From page 7 neglect has occurred. The above P & P failed to establish a written process to investigate the allegations. In addition, the P & P failed to include that the results of all investigations are to be forwarded to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident. Finally, the P & P failed to include if the alleged violation is verified appropriate corrective action must be taken. 2/25/19 at approximately 3:00 PM - An interview with E2 (NHA) was held and E2 was advised of the lack of reporting requirements in the above P & P. 2/28/19 beginning at approximately 4:00 PM - Findings were reviewed with E1 (CEO), E2 (NHA), E3 (DON), and E4 (DOR) during the Exit Conference. | F 607 | | | |
| F 608 SS=E | Reporting of Reasonable Suspicion of a Crime CFR(s): 483.12(b)(5)(i)-(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. (i) Annually notifying covered individuals, as defined at section 1150B(a)(3) of the Act, of that individual's obligation to comply with the following reporting requirements. (A) Each covered individual shall report to the State Agency and one or more law enforcement | F 608 | | 4/19/19 | |

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| F 608 | <p>Continued From page 8</p> <p>entities for the political subdivision in which the facility is located any reasonable suspicion of a crime against any individual who is a resident of, or is receiving care from, the facility.</p> <p>(B) Each covered individual shall report immediately, but not later than 2 hours after forming the suspicion, if the events that cause the suspicion result in serious bodily injury, or not later than 24 hours if the events that cause the suspicion do not result in serious bodily injury.</p> <p>(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act.</p> <p>(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and review of the facility's policy and procedure ("P & P"), it was determined that the facility failed to develop and implement written policies and procedures that included requirements for suspicious crime. Findings include:</p> <p>Cross refer F607.</p> <p>Review of the facility's undated P & P, entitled "Abuse", lacked evidence of reporting requirements for a suspicious crime.</p> <p>2/25/19 at approximately 3:00 PM - An interview with E2 (NHA) confirmed that the current policy failed to include reporting requirements for suspicious crime.</p> <p>2/28/19 beginning at approximately 4:00 PM - Findings were reviewed with E1 (CEO), E2 (NHA), E3 (DON), and E4 (DOR) during the Exit Conference.</p> | F 608 | <p>A. Abuse policy and procedure reviewed and updated to include reporting requirements for a suspicious crime. No resident was harmed.</p> <p>B. Facility shall ensure that all staff are aware of reporting requirements and to support an environment in which staff and others report all alleged violations of mistreatment, exploitation, neglect or abuse, including injuries of unknown source and misappropriation of resident property. Staff will be educated on abuse policy and procedure with emphasis reporting requirements for a suspicious crime and investigate all allegations regardless of severity. Examples of situations that would likely be considered crimes include, but are not limited to: Murder, Manslaughter, Rape, Assault & Battery, Sexual Abuse/Assault, Theft/Robbery, Drug diversion for personal use or gain, Identity Theft, Fraud and Forgery.</p> | | |

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| F 608 | Continued From page 9 | F 608 | C. Protection of residents can be compromised or impeded if individuals are fearful of reporting, especially if the alleged abuse has been carried out by a staff member. In response to allegations of abuse, neglect, exploitation, or mistreatment, process will be started immediately. Abuse policy reviewed and updated to establish a written process to investigate allegations as well as the results of all investigations are to be forwarded to the to the State Agency and one or more law enforcement entities immediately, but no later than 2 hours if the event results in seriously bodily injury and no later than 24 hours if the events that cause the suspicion do not result in bodily injury. Any new updates will be reviewed with staff. D. Abuse policy will be reviewed and updated annually with the Quality Assurance team. Administrator will ensure facility's compliance. Completion Date by 4/19/19 using means of mandatory in-servicing for all staff. | | |
| F 609 SS=D | Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if | F 609 | | 4/28/19 | |

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| F 609 | <p>Continued From page 10</p> <p>the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.</p> <p>§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, interview, and review of other facility documentation, as indicated, it was determined for one (R116) out of one sampled resident reviewed for abuse, the facility failed to immediately report an allegation of physical abuse. Findings include:</p> <p>Cross refer F607. Cross refer F610.</p> <p>Review of the facility's undated policy and procedure ("P & P"), entitled "Abuse", revealed the following:</p> <ul style="list-style-type: none"> - Staff members suspecting abuse, neglect or mistreatment must fill out an incident report, write a Statement of Fact and include any witnesses, if applicable. - The incident must be reported to the DON, ADON, or charge nurse. - If the DON so concludes, then the State is notified of suspected abuse, neglect or mistreatment. | F 609 | <p>A. Resident 116 was discharged from facility 12/4/18. Previous SW and NHA are no longer employed by the facility.</p> <p>B. Facility has determined that all residents have the potential to be affected. Facility Administrator interviewed all current residents to inquire if they feel safe, their needs are met and to ensure that any injuries and/or complaints are identified, properly investigated and reported to the appropriate people. Results of interviews did not reveal any safety concerns by residents. All interviews were documented in QA file and will be reported in the monthly QA meeting.</p> <p>C. Policy & Procedure F609 Reporting of Alleged Violations was reviewed and updated to include reporting requirements for alleged violations (see attached). Facility Administrator educated DON on reporting of alleged violations. All</p> | |

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| F 609 | <p>Continued From page 11</p> <p>12/11/18 - Review of the State Agency's Investigative File revealed on 11/19/18, State Agency Investigator (SAI) met with previous NHA (E15), E3 (DON) and previous SW (E16), who confirmed that the facility was made aware of an allegation of physical abuse made by R116's family member, in which the male staff grabbed R116's wrist. According to the investigative file, this alleged abuse occurred on 10/18/18 or 10/19/18.</p> <p>There was lack of evidence of immediate reporting of the allegation of physical abuse made by R116's family member, which occurred on 10/18/18 or 10/19/18.</p> <p>2/28/19 at approximately 1:27 PM - An interview with E3 (DON) revealed E3 recalled the allegation of physical abuse by a staff member. E3 related that reporting to the State Agency was determined by the previous NHA, E15.</p> <p>The facility failed to have evidence of immediate reporting of an allegation of physical abuse.</p> <p>2/28/19 beginning at approximately 4:00 PM - Findings were reviewed with E1 (CEO), E2 (NHA), E3 (DON), and E4 (DOR) during the Exit Conference.</p> | F 609 | <p>employees were educated on facility's abuse policy and procedures with emphasis on reporting requirements for an alleged violation/crime (attendance sheet is attached). All reported and/or suspected violations will be documented on facility Incident Report and immediately investigated and reported as per policy. All new employees will receive education on reporting alleged violations (F609) during orientation (see attached). Going forward mandatory compliance education will be provided on at least an annual basis. Administrator or designee will audit all reportable incident files and current allegations to determine if incidents were reported timely to the appropriate agencies.</p> <p>D. Reportable incidents will be reviewed and signed off on to ensure that the timely reporting has occurred in 100% of the incidents. Facility incident report will be utilized as the audit tool and has been revised to include abuse, neglect, mistreatment (attachment 4). Results will be reported at the weekly leadership team meeting. At the monthly QA meeting, compliance will be monitored by reviewing all incident reports to ensure that timely reporting occurred in 100% of incidents. Quarterly QAPI meetings will track this compliance. Administrator/ designee will present the summary report of the committee findings to the quarterly QAPI meetings permanently to ensure 100% compliance is maintained.</p> | |
| F 610 SS=D | <p>Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4)</p> <p>§483.12(c) In response to allegations of abuse,</p> | F 610 | | 4/28/19 |

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| F 610 | <p>Continued From page 12</p> <p>neglect, exploitation, or mistreatment, the facility must:</p> <p>§483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.</p> <p>§483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.</p> <p>§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, interview, and review of other facility documentation as indicated, it was determined for one (R116) out of one sampled resident reviewed for abuse, the facility failed to have evidence that an allegation of physical abuse was thoroughly investigated. Findings include:</p> <p>Cross refer F607. Cross refer F609.</p> <p>Review of the facility's undated policy and procedure, entitled "Abuse Policy and Procedure" ("P & P"), revealed the following:</p> <ul style="list-style-type: none"> - Staff members suspecting abuse, neglect or mistreatment must fill out an Incident Report, write a Statement of Fact and include any witnesses, if applicable. - An internal investigation will occur for the next 72 hours to determine if there is reasonable cause to believe that abuse, mistreatment, or | F 610 | <p>A. Resident 116 was discharged from facility 12/4/18. No resident was harmed. Previous SW and NHA are no longer employed by the facility.</p> <p>B. Facility has determined that all residents have the potential to be affected.</p> <p>C. Policy and Procedure was revised 2/25/19 and establishes a written process to investigate allegations and if alleged violation is verified, corrective action will be taken. All results of the investigations are to be forwarded to NHA or designee and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident. DON was educated on reporting all allegations regardless of severity to the State. An in-service education program was conducted by the DON and facility Administrator on 2/25/19 with all direct</p> | |

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| F 610 | <p>Continued From page 13 neglect has occurred.</p> <p>The above P & P failed to establish a written process to investigate the allegations. In addition, the P & P failed to include that the results of all investigations are to be forwarded to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident. Finally, the P & P failed to include if the alleged violation is verified appropriate corrective action must be taken.</p> <p>12/11/18 - Review of the State Agency's Investigative File revealed on 11/19/18, State Agency Investigator (SAI) met with previous NHA (E15), E3 (DON) and previous SW (E16), who confirmed that the facility was made aware of an allegation of physical abuse made by R116's family member, in which the male staff grabbed R116's wrist. According to the investigative file, this alleged abuse occurred on 10/18/18 or 10/19/18.</p> <p>Review of the facility's Incident Reports lacked evidence that the above allegation of physical abuse was thoroughly investigated.</p> <p>2/28/19 at approximately 1:27 PM - An interview with E3 (DON) confirmed that E3 recalled the allegation of physical abuse by a staff member. E3 verbalized that the facility investigation included interviewing R116, however, E3 was unable to provide any evidence of the investigation.</p> <p>The facility failed to have evidence that an allegation of physical abuse was thoroughly investigated.</p> | F 610 | <p>care staff addressing circumstances that require reporting for timely investigations, and their responsibilities related to investigations. Validation checklist (attached) provides 6 corrective action steps of investigating an injury of unknown origin as follows:</p> <ol style="list-style-type: none"> 1) Review circumstances of the injury 2) Evaluate the effect of the injury on the resident 3) Who was notified (date/time) 4) Was injury reported in a timely manner? 5) Was a thorough investigating completed? 6) Were results of the investigation reported within five working days? <p>Facility Administrator will conduct a thorough investigation and will document all findings and make report in accordance with federal and state guidelines as per policy (attached).</p> <p>D. An audit of all incidents will be conducted by DON or designee and administrator to ensure alleged violations are thoroughly investigated. DON or designee and facility All audits will be reviewed daily in Leadership Stand-Up meetings for three weeks to ensure 100% compliance is reached. After the audits shows show 100% compliance for three weeks, the audits will be reduced to two times per week for three weeks to ensure 100% compliance has been maintained. After 100% compliance has been maintained the audits will be reduced to 1 per week for three weeks. The administrator or designee will be responsible for the completion of this Plan of Correction. This Plan of Correction will</p> | | |

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| F 610 | Continued From page 14 2/28/19 beginning at approximately 4:00 PM - Findings were reviewed with E1 (CEO), E2 (NHA), E3 (DON), and E4 (DOR) during the Exit Conference. | F 610 | be discussed at the monthly QA meetings to ensure 100% compliance is maintained. Findings of this audit will be discussed with Resident Council and documented in Compliance Log. Corrective action completion date: 4/28/19. | | |
| F 641 SS=D | Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R15) out of 11 sampled residents for investigation, the facility failed to ensure that the MDS assessments accurately reflected the resident's oral status. Findings include: Cross refer F790. Review of R15's clinical record revealed: 10/12/17 - R15 was admitted to the facility. 10/14/18 - A significant Change MDS assessment failed to include that R15 had missing or broken teeth. 12/27/18 - A quarterly MDS assessment failed to include that R15 had missing or broken teeth. 2/21/19 at 2:37 PM - R15 was observed with multiple missing and broken teeth. 2/27/19 at approximately 2:55 PM - An interview with E10 (CNA) revealed that R15 has had | F 641 | A. Previous RNAC deemed to be root cause for inaccuracies in MDS assessment is no longer employed by facility. R15 MDS modified 3/5/19 to accurately reflect resident's oral status. R15 care plan will be updated to reflect the resident's oral status. No resident was harmed. B. Facility will review section L of the MDS and residents identified with a MDS that does not correctly reflect the oral status will have the MDS assessment modified. Resident care plans will be updated. RNAC will be in-serviced on this procedure. ongoing review of the resident care plan will be done. Any changes made will be reviewed with care plan IDT to ensure all information is accurate. C. Dental Services Policy and Procedure reviewed and revised. Continuous monitoring of the care plan with quarterly and comprehensive reviews to make sure solutions are sustained. RNAC will conduct visual assessment of the oral cavity of each resident to determine if | 4/28/19 | |

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| F 641 | Continued From page 15 broken teeth for some time. 2/27/19 at approximately 3:00 PM - An interview with E3 (DON) confirmed that the above MDS assessments failed to accurately reflect R15's missing and broken teeth. 2/28/19 beginning at approximately 4:00 PM - Findings were reviewed with E1 (CEO), E2 (NHA), E3 (DON), and E4 (DOR) during the Exit Conference. | F 641 | resident: has teeth or is edentulous, has tooth fragments present, has abnormal mouth tissue, obvious cavities, loose or broken teeth, inflamed or bleeding gums, mouth pain or difficulty chewing and document accurate condition of oral cavity to MDS on quarterly basis. If inaccuracies are found, root cause analysis will be conducted and system failure will be remedied. Any system failures found will be reported the next QAAP meeting. Nursing staff will be educated on dental policy. D. Success evaluation - DON/designee will conduct a monthly audit for the next 12 months of all residents dental status and compare exam results against section L of each MDS to ensure 100% accurate MDS coding. Any errors in MDS coding identified will be modified to reflect accurate status of mouth, teeth and gums for every resident. All residents in the facility will have accurate identification of status of oral cavity documented in section L of every comprehensive and quarterly MDS by 4/28/2019. This plan of correction will be monitored at the monthly Quality Assurance meeting to achieve 100% compliance. Corrective action date: 4/28/19. Results of audits will be reviewed during quarterly QAPI meetings. QAPI committee will identify trends and make recommendations based on audit results. Findings of this audit will be discussed with the Resident Council. | | |
| F 656 SS=D | Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and | F 656 | | 4/19/19 | |

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| F 656 | Continued From page 16 implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: | F 656 | | | |

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| F 656 | <p>Continued From page 17</p> <p>Based on record review and interview, it was determined that for two (R2 and R15) out of 11 sampled residents for investigation, the facility failed to develop and implement care plan interventions. For R2 and R15, the facility failed to develop and implement care plan interventions to address the limited range of motion (ROM). In addition, the facility failed to develop and implement a care plan to address the residents'(R2) nail care needs. Findings include:</p> <p>Cross refer F688, example #1.</p> <p>1a. Review of R2's clinical record revealed:</p> <p>7/3/18 - Admitted to the facility.</p> <p>7/5/18 - A care plan for impaired physical mobility related to contraction (sic) on left upper extremity secondary to stroke and one-sided weakness. The goal was that resident will maintain optimal functional mobility during this review period. Interventions included to monitor/document/report any changes in R2's movement/ROM, report to charge nurse and for physical therapy/occupational therapy assessment and treatment, as indicated.</p> <p>There was lack of evidence of interventions related to R2's left upper extremity ROM limitations.</p> <p>7/10/18 - An admission MDS assessment documented that R2 had ROM impairments on the one side of her/his body, affecting both upper extremities (UE) and lower extremities (LE).</p> <p>Cross refer F677.</p> <p>1b. Review of R2's clinical record revealed the</p> | F 656 | <p>A. R2 Care plan will be updated to reflect upper extremity range of motion limitations. R2 care plan will be updated to include interventions for nail care. R15 care plan will be updated to reflect new range of motion impairments on both lower extremities. No resident was harmed.</p> <p>B. Facility will review residents during their quarterly care plan meeting with interdisciplinary team to ensure a comprehensive person-centered care plan is developed and implemented. Resident's preferences and goals, and measurable objectives and timeframes are revised to meet a resident's medical, nursing, and mental and psychosocial needs identified in the comprehensive assessment.</p> <p>C. Care plan policy reviewed and revised to ensure facility creates and develops person centered care plan for each resident. Staff will be in-serviced on care plan policy with emphasis on developing a person-centered care plan for each resident, consistent with the resident rights.</p> <p>D. RNAC will review residents during their care plan meeting with interdisciplinary team weekly x 4 and then ongoing monthly until 100% accuracy to ensure a comprehensive person-centered care plan is implemented and developed. Results of the audit will be reviewed regularly at the QAAP meetings. Completion Date by 4/19/19 using means of mandatory in-servicing for all staff, especially interdisciplinary team.</p> | | |

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| F 656 | <p>Continued From page 18 following:</p> <p>7/3/18 - Admitted to the facility with one-sided weakness due to a stroke.</p> <p>7/10/18 - Admission MDS assessment documented that R2 required extensive assistance of one staff member to meet his/her personal hygiene needs and s/he had range of motion (ROM) impairment affecting one side of the body for both upper extremities (UE's) and lower extremities (LE's).</p> <p>7/11/18 - A care plan for ADL deficit documented that R2 required assistance with bathing, dressing, safe transfer, toileting, and set-up for eating. The goal indicated that R2 will exhibit improved function for transfer, personal hygiene, and eating.</p> <p>The care plan failed to include interventions for nail care.</p> <p>Cross refer F688, example #2.</p> <p>2. Review of R15's clinical records revealed:</p> <p>10/12/17 - Admitted to the facility.</p> <p>10/4/18 - A significant change MDS assessment documented that R15 had no ROM impairment.</p> <p>12/27/18 - A quarterly MDS assessment documented that R15 had a new ROM impairments affecting both lower extremities.</p> <p>There was lack of evidence of a care plan to address the new ROM impairments.</p> <p>2/28/19 beginning at approximately 4:00 PM -</p> | F 656 | | |

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| F 656 | Continued From page 19 Findings were reviewed with E1 (CEO), E2 (NHA), E3 (DON), and E4 (DOR) during the Exit Conference. No additional evidence was provided to the surveyor during the survey. | F 656 | | | |
| F 657 SS=D | Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for two (R1 and R2) out of 11 sampled residents for investigations, the facility failed to ensure that care plans were developed | F 657 | A. Facility is unable to retroactively correct R1 and R2 care plan meetings. R1 care plan was updated 3/12/19 and the care plan review was completed | 4/28/19 | |

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| F 657 | <p>Continued From page 20</p> <p>by the IDT which included the attending physician, a nurse aide with responsibility for the resident, and a member of food and nutrition services staff. The facility failed to revise the care plan to reflect current intervention for one (R3) out of 30 sampled residents for investigation. Findings include:</p> <p>1. The following was reviewed in R1's clinical record:</p> <p>6/6/18 - A significant change MDS assessment was completed. Record review lacked evidence of an IDT care plan meeting following the assessment.</p> <p>8/19/18 - A quarterly MDS assessment was completed. Record review lacked evidence of an IDT care plan meeting was held following the assessment.</p> <p>11/13/18 - A quarterly MDS assessment was completed. Record review lacked evidence of an IDT care plan meeting was held following the assessment.</p> <p>2/22/19 at approximately 1:15 PM - An interview with E6 (RNAC) revealed that s/he assumed the role in December 2018 and was not certain if there was a written procedure, as it related to coordination of the IDT care plan meetings. E6 verbalized that s/he will be implementing an invitation letter for upcoming IDT care plan meetings beginning next month in March 2019. During this interview, the surveyor requested the facility's evidence that R1 and his/her guardian were invited to each of the IDT meetings. E6 related that it was not the current facility's practice to have the attending physician present for the meeting.</p> | F 657 | <p>3/13/19. R1 attended care conference. R2 care conference and review was completed 3/26/19. R2 was invited to attend but declined. R3 care plan was revised and updated to reflect current interventions on 3/26/19. R3 attended the care conference. No resident was harmed.</p> <p>B. All residents of the facility have the potential to be affected by this practice. All interdisciplinary team members who are responsible for coordinating care plan conferences will be reeducated on the facility's policy and procedure: Care Plan Timing and Revision. RNAC or designee will send invitation letters to all IDT members, resident, and responsible parties for all upcoming interdisciplinary care meetings. RNAC or designee will ensure IDT members sign as a record of attendance for all involved personnel including physician, nurse aides and members of food and nutrition services.</p> <p>C. Facility standardizing its care plan schedule will streamline the process for revision and ensure the facility maintains its periodic review and update of resident care plans. RNAC will have a care conference invitations prepared and delivered by mail or by telephone, to residents and/or responsible party 7-10 days in advance of scheduled care conference dates. RNAC will present copies of these invitations to NHA, annotated with date(s) sent, responses, and communications for auditing weekly. RNAC/ designee will maintain a binder of all care conference invitations and check care conference dates against MDS schedule for accuracy. RNAC will audit to</p> | |

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| F 657 | <p>Continued From page 21</p> <p>2/25/19 at approximately 1:16 PM - A follow-up interview with E6 (RNAC) confirmed that the facility had no evidence that an IDT care plan meeting was held after the above MDS assessments. E6 verbalized that an IDT care plan meeting was scheduled for 3/5/19 and an invitation letter has been sent to R1's guardian.</p> <p>2. The following was reviewed in R2's clinical record:</p> <p>10/10/18 - A quarterly MDS assessment was completed.</p> <p>10/30/18 - An IDT care plan meeting was held and R2 was present in the meeting, however, R2's attending physician and a member of food and nutrition services staff were not present. Thus, the facility failed to have evidence, that the IDT reviewed and revised the care plans after this assessment.</p> <p>1/8/19 - A quarterly MDS assessment was completed. Record review lacked evidence that an IDT care plan meeting was held after the completion of the assessment.</p> <p>2/25/19 at approximately 1:50 PM - An interview with E6 (RNAC) confirmed that the 10/30/18 care plan meeting did not include R2's attending physician, E8 or a staff from the food and nutrition department. In addition, E6 confirmed that the facility failed to have evidence that an IDT meeting happened after the 1/8/19 assessment was conducted.</p> <p>3. The following were reviewed in R3's clinical record:</p> <p>9/24/18 - Admitted to facility with diagnosis of</p> | F 657 | <p>ensure care conference schedule matches scheduled MDS dates (monthly schedules are completed in advance). Facility will ensure that 100% of residents have accurate updated person centered comprehensive care plans with goals and interventions addressing physical, emotional, and psychosocial needs by 4/28/19. Facility will ensure that 100% of residents will have care plan review meetings, with IDT members, held no greater than every 92 days according to the current monthly MDS schedule on an ongoing basis. Facility will ensure that all members of IDT receive a copy, in advance, of care conference schedule with date, time and ARD of MDS for each resident scheduled for care plan meeting. RNAC will prepare all care plans for review/revision by IDT members by opening new care plan reviews in PCC in the window of the 7-day look period of MDS ARD. NHA will audit open care plan reviews weekly according to MDS schedule. RNAC will monitor IDT continuously to review/revise care plan goals and interventions PRN and in look back period of MDS. RNAC will monitor IDT members to sign care plan reviews completed at the end of each care conference after team has reviewed problems/goals/interventions.</p> <p>D. RNAC, or designee, will conduct weekly random audits of five (5) resident care plans for a period of four (4) consecutive weeks to ensure 100% compliance with the following 7 items: (1) Documentation that resident/representation was invited to care conference</p> | | |

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| F 657 | <p>Continued From page 22</p> <p>Unsteadiness on Feet/ Difficulty Walking</p> <p>9/25/18 (Initiated 1/22/19) - An active Care Plan identifying nutritional problem related to unplanned weight loss, poor intake and anemia with intervention including "weigh at same time of day and record weekly. The resident is weighed using the wheelchair scale."</p> <p>10/29/18 - Physician Order for weekly weights</p> <p>12/27/19 - Comprehensive MDS (Minimum Data Set) assessment on 12/27/18 reflect that resident has unplanned weight loss.</p> <p>1/15/19 - Physician Order to walk patient with walker everyday</p> <p>2/25/19 4:53 PM - An interview with E13 (LPN) stated that "Resident is on weekly weights consistently using wheelchair in obtaining weights."</p> <p>2/26/19 9:00 AM - Review of R3's weekly weight records from 10/15/18 through 2/25/19 revealed that R3's weights were obtained through different methods using the hoyer lift scale (hoyer lift - a sling-type mechanical lift), wheelchair scale and standing scale.</p> <p>2/26/19 10:00 AM - Review of Physician's Order lacked evidence of physician's order for "weighed using standing scale"</p> <p>2/26/19 10:19 AM - Interview with E10 (CNA) confirmed and stated that, "I'm in charge of obtaining her weight when I am working. I let her stand up on the weighing scale in order to get her weight. She can stand since she has been on therapy. It's not indicated in the computer for us</p> | F 657 | <p>(2) Care plan with IDT is held no greater than 92 days from previous</p> <p>(3) Documentation IDT invitation sent in advance of care conference date/time</p> <p>(4) Care conference schedules match MDS dates</p> <p>(5) Care plan has been adjusted to reflect outcome of the care plan conference</p> <p>(6) Care plan has been revised to reflect current interventions</p> <p>(7) IDT team signatures are documented for all mandatory disciplines</p> <p>Once 100% compliance is achieved, randomized sample of five (5) resident care plans will be audited every month for three months and the results presented at quarterly QAPI. This plan of correction will be monitored at quarterly QAPI meetings on an ongoing basis to ensure 100% compliance is maintained. QAPI committee will identify trends and make recommendations based on audit results. Corrective action completion date: 4/28/19.</p> | | |

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| F 657 | Continued From page 23 to sign off if she is to be weighed using the wheelchair." 2/28/19 3:00 PM - Interview with E3 (DON) confirmed and said that "...The care plan discrepancy was an oversight. Resident is using the standing scale; she has been walking with therapy. We are updating the careplan." 2/28/19 beginning at approximately 4:00 PM - Findings were reviewed with E1 (CEO), E2 (NHA), E3 and E4 (DOR) during the Exit Conference. | F 657 | | | |
| F 677 SS=D | ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and review of related clinical information, it was determined that the facility failed to ensure a resident who was unable to carry out activities of daily living receives the necessary services to maintain personal hygiene for one (R2) out of one sampled residents for ADL review. Findings include: Cross refer F656, example #1b. Review of R2's clinical record revealed the following: 7/3/18 - Admitted to the facility with one-sided weakness due to a stroke. | F 677 | A. R2 fingernails were trimmed and cleaned 2/26/19. R2 ADL care plan updated to include providing nail care. No resident was harmed. B. Facility will identify residents who are unable to carry out the activities of daily living and ensures that residents receive the necessary services to maintain personal hygiene. Resident care plans will be updated. Nursing aide task reviewed and implemented in Point of Care (POC) to ensure that nurses and nurses aides have access to track nail care. C. ADL policy and procedure and Nail Care policy and procedure revised to | 4/19/19 | |

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| F 677 | <p>Continued From page 24</p> <p>7/10/18 - The admission MDS assessment documented that R2 required extensive assistance of one staff member to meet his/her personal hygiene needs and s/he had range of motion (ROM) impairment affecting one side of the body for both upper extremities (UE's) and lower extremities (LE's).</p> <p>7/11/18 - A care plan for ADL deficit documented that R2 required assistance with bathing, dressing, safe transfer, toileting, and set-up for eating. The goal indicated that R2 will exhibit improved function for transfer, personal hygiene, and eating. The interventions failed to include providing nail care.</p> <p>10/10/18 - A quarterly MDS assessment documented that R2 required extensive assistance of one staff for personal hygiene and ROM impairment remained unchanged.</p> <p>1/8/19 - A quarterly MDS assessment documented that R2 required supervision and assistance of one staff to perform her/his personal hygiene and ROM impairment remained unchanged.</p> <p>2/21/19 at approximately 1:19 PM - R2 was observed with bilateral hand nails that were untrimmed with encrusted debris underneath the nail. The fingernails extended approximately half an inch past the fingertips with clenched fist. This was concerning as R2's fingernails could dig into the left palm.</p> <p>2/26/19 at approximately 11:00 AM - R2's bilateral fingernails remained untrimmed with encrusted brown debris.</p> | F 677 | <p>ensure residents who are unable to carry out activities of daily living receive the necessary services to maintain personal hygiene. Policy will be in-serviced to nursing staff. Procedure in place so that Nurses and nurses <input type="checkbox"/> aides have access to review and track nail care. Tracking tasks in PCC</p> <p>D. Root cause analysis shows that resident tendency to decline ADL care as well as a need for an improved tracking system. Care plans updated for refusals and preferences with a procedure in place for reviewing and tracking nail care. RNAC/designee will audit nail care weekly x 12 weeks then ongoing monthly until 100% accuracy to ensure residents are receiving necessary services for grooming and personal hygiene. Results of the audits will be reviewed at the regularly scheduled QAAP meetings. Completion Date by 4/19/19 using means of mandatory in-servicing for all staff, especially interdisciplinary team.</p> | |

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| F 677 | <p>Continued From page 25</p> <p>2/26/19 at approximately 11:25 AM - An interview with E7 (LPN) revealed both nursing and activity departments staff may perform cleaning the nail, however, only nursing staff are allowed to trim the nails.</p> <p>2/26/19 at approximately 11:58 AM - Nail care, including trimming and cleaning was performed by E7 in R2's room. Following the nail care, strong, foul odor was noted by the surveyor, coming from R2's room, into the hallway of the unit and confirmed by E7. R2 was observed with trimmed nails without encrusted debris.</p> <p>2/26/19 at approximately 1:30 PM - E3 (DON) provided a copy of the progress note to the surveyor, in which R2 has refused nail care on 2/6/19, approximately 20 days earlier. There was a lack of evidence when the nail care was refused on 2/6/19, that the facility re-offered nail care to R2, who was unable to perform his/her nail care.</p> <p>2/28/19 beginning at approximately 4:00 PM - Findings were reviewed with E1 (CEO), E2 (NHA), E3 (DON), and E4 (DOR) during the Exit Conference.</p> | F 677 | | |
| F 688 SS=D | <p>Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3)</p> <p>§483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and</p> <p>§483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to</p> | F 688 | | 4/28/19 |

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| F 688 | <p>Continued From page 26 prevent further decrease in range of motion.</p> <p>§483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review and interview, it was determined that the facility failed to provide appropriate treatment and services to increase range of motion (ROM) and/or to prevent further decrease in ROM for two (R2 and R15) out of four residents sampled for ROM limitations. Findings include:</p> <p>Cross refer F656, example 1a.</p> <p>1. Review of R2's clinical record revealed:</p> <p>7/3/18 - Admitted to the facility.</p> <p>7/5/18 - A care plan for impaired physical mobility related to contraction on left upper extremity secondary to a stroke and weakness of one side of the body. The goal was that resident will maintain optimal functional mobility during this review period.</p> <p>Interventions included to monitor/document/report any changes in R2's movement/ROM, report to charge nurse and for Physical Therapy/Occupational Therapy assessment and treatment as indicated.</p> <p>There was lack of evidence, of interventions for R2's left upper extremity ROM limitations.</p> <p>7/10/18 - An admission MDS assessment documented that R2 had ROM impairments on</p> | F 688 | <p>R2 & R15 were screened by Director of Rehab for ROM/contracture on April 4, 2019. Results of the screens indicated that R2 was a candidate for ROM evaluation and R2 was referred and evaluated by Physical Therapist on April 4, 2019. R2 is making progress in Physical Therapy and the plan is to discharge resident to restorative nursing program once therapy goals are met. R15 was screened by Director of Rehab April 4, 2019 and was referred for Occupational Therapy assessment which is scheduled for April 13, 2019. No resident was harmed.</p> <p>B. All residents of the facility have the potential to be affected by this practice. Therefore, all current residents will be administered a ROM screen and Restorative Nursing assessment by Director of Rehab to obtain resident's baseline range of motion (such as current extent of movement of his/her joints and the identification of limitations) and mobility needs. Baseline ROM and mobility needs for all residents will be recorded in resident's chart and recommendations added to the care plan. Director of Rehab administered Baseline ROM screen to 12/16 residents April 28, 2019. Restorative Nursing assessments</p> | |

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| F 688 | <p>Continued From page 27</p> <p>the one side of her/his body, affecting both upper extremities (UE's) and lower extremities (LE's). There was a lack of a comprehensive ROM assessment in the clinical record.</p> <p>10/10/18 - A quarterly MDS assessment documented R2's ROM impairments unchanged from the previous MDS assessment.</p> <p>1/8/19 - A quarterly MDS assessment documented no changes in R2's ROM impairments.</p> <p>2/21/19 at approximately 1:17 PM - R2 was observed ambulating independently with left upper extremity ROM limitations and left hand contracture. R2 denied pain in the left hand and verbalized that the left upper extremity limitations remains relatively unchanged since admission to the facility.</p> <p>2/26/19 at approximately 9:45 AM - An interview with E4 (Director of Rehabilitation) revealed the facility had no written expectations of ROM and contracture assessments, however, the facility had developed and implemented a policy on 2/21/19, in which ROM and contractures will be assessed. E4 confirmed R2 was not receiving any treatment or services to address his/her ROM limitations.</p> <p>2/27/19 at approximately 10:00 AM - E4 (DOR) provided a ROM assessment that was completed on 2/27/19, which documented limited ROM of left elbow, left wrist, and left knee. Additionally, E4 provided the facility's policy and procedure dated 2/2019 entitled "Range of Motion Screens". This policy contained a five page document entitled "Name of Skill: Range of Motion".</p> | F 688 | <p>for all residents and ROM screens for the 4 remaining residents will be administered and completed by 4/28/19. Based on results of these ROM screens and Restorative assessments, resident centered ROM/mobility needs will be identified and recommendations for restorative care or therapy will be made. All assessments of current residents will be completed by April 28, 2019. Going forward, Restorative Nursing Assessments and Baseline ROM/mobility screens shall be administered to all new residents on admission/readmission, as well as quarterly, and upon a significant change, and discharge from therapy. Nursing assistants will report any significant changes in range of motion, as noted during daily care activities, to the resident's nurse when any changes are noted.</p> <p>C. A root cause analysis revealed that this deficient practice resulted from a lack of consistency in adhering to the facility's restorative nursing protocol when staff members transitioned (staff left and new staff were hired). Based on this root cause analysis training on restorative nursing care will be provided to all nurses and nursing assistants immediately and annually thereafter and for all new staff during orientation. Restorative Nursing Policy and Procedures was updated Director of Rehab and Nurse Educator will be responsible for training all facility's staff on updated policy and procedures for the restorative nursing program (attached).</p> <p>D. Success Evaluation - MDS</p> | |

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| F 688 | <p>Continued From page 28</p> <p>The facility failed to complete an admission ROM and contracture assessment. This resulted in a lack of appropriate treatment and services to increase ROM or to prevent further potential for decrease in ROM.</p> <p>Cross refer F656, example #2.</p> <p>2. Review of R15's clinical records revealed:</p> <p>10/12/17 - Admitted to the facility.</p> <p>10/4/18 - A significant change MDS assessment documented that R15 had no ROM impairment.</p> <p>12/27/18 - A quarterly MDS assessment documented that R15 had a new ROM impairment affecting bilateral lower extremities. There was lack of evidence of a ROM assessment and/or a care plan.</p> <p>2/21/19 at approximately 2:52 PM - An interview with E4 (DOR) revealed that R15 was receiving physical therapy until 2/20/19. Surveyor requested for ROM assessment for R15 from E4.</p> <p>2/26/19 at approximately 9:45 AM - A subsequent interview with E4 (DOR) revealed that a ROM assessment will be completed on R15 as the facility had no record of a previous ROM assessment.</p> <p>2/27/19 at approximately 10:00 AM - E4 (DOR) provided a ROM assessment dated 2/27/19, which documented limitations of both knees and ankles.</p> <p>The facility failed to complete an admission ROM and contracture assessment. In addition, when R15 had a new ROM impairment, as documented</p> | F 688 | <p>coordinator or designee will complete audits weekly X 4 weeks to identify any missed opportunities for restorative therapy, ensure residents have a baseline ROM/mobility assessment and ROM screen on admission/readmission, as well as quarterly, and upon a significant change, and discharge from therapy until 100% compliance is achieved. Audit will also ensure that results are documented in residents' care plan and progress and recommendations are noted. until 100% compliance is achieved Audits will then be monthly X 3 until 100% compliance, then quarterly. To ensure continued success of compliance with this program quarterly audits will remain in effect permanently. Results of audits will be reviewed during quarterly QAPI meetings. QAPI committee will identify trends and make recommendations based on audit results.</p> <p>Attachments:</p> <ol style="list-style-type: none"> 1. Policy & Procedure: Prevention of Decline Range of Motion/Mobility 2. Training & Practice Guideline - Staff Training Tool: ROM Screen/Restorative 3. Validation Checklist: Range of Motion/Mobility Screen/Restorative Nursing Assessment 4. Record of In-service Training & Attendance Form: Range of Motion/Mobility Restorative Nursing Program 5. QAPI Committee Audit Form: ROM/Mobility Restorative Nursing Program 6. Restorative Program Care Plan & Summary Form | | |

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| F 688 | Continued From page 29 on the 12/27/18 MDS assessment, the facility failed to assess R15's ROM limitations. These failures resulted in the facility's inability to determine the appropriate treatment and to assess the affect on R15's ROM. 2/28/19 beginning at approximately 4:00 PM - Findings were reviewed with E1 (CEO), E2 (NHA), E3 (DON), and E4 (DOR) during the Exit Conference. | F 688 | 7. Policy & Procedure: Restorative Nursing Program | | |
| F 690 SS=G | Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(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. §483.25(e)(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 unless the resident's clinical condition demonstrates that catheterization was necessary; (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 (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. | F 690 | | 4/28/19 | |

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| F 690 | <p>Continued From page 30</p> <p>§483.25(e)(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.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations, interviews, review of clinical records and other facility documentation, it was determined that the facility failed to ensure appropriate treatment and services to restore and/or maintain bladder function were implemented for one (R9) out of 1 sampled resident for incontinence review. The facility failed to identify and recognize during the three quarterly assessments that R9 experienced an increasing incidence of urinary incontinence (UI - the involuntary loss of urine) including a decline in continence. These failures resulted in the lack of a comprehensive assessment including a three day voiding diary, development of a plan of care, and implementation of appropriate interventions to maintain and/or restore bladder function. This resulted in harm when R9's urinary continence declined from 64% continent in April 2018 to 40% in June 2018, 9% in September 2018 and 12% in December 2018.</p> <p>Findings include:</p> <p>The facility's undated Procedure on Urinary Continence and Incontinence - Assessment and Management stated that "#3. Periodically (as required and when there is a change in voiding), staff will define each individual's level of continence, referring to the criteria in the MDS (Minimum Data Set) ...#17. As indicated, and if the individual remains incontinent despite treating</p> | F 690 | <p>A. The facility is unable to retroactively assess for the decline in urinary incontinence. Resident has consistently scored as severely impaired on BIMS assessment since admission. She is able to make simple needs known. 72 hour bowel and bladder flow sheet initiated 3/28/19. R9 was trialed on toileting program. The residents care plan was updated to reflect urinary incontinence care program. No resident was harmed.</p> <p>B. Facility will identify residents who may be a candidate for urinary incontinence program using the 72 hour bowel and bladder flow sheet. Results will be recorded in resident's medical record. Toileting program may be initiated for any resident meeting criteria for the program. Resident care plans will be updated to address the program. Recommendations implemented based on results.</p> <p>C. The root cause analysis showcases need for improvement in a multi-system approach. The update to a 72 hour bowel and bladder diary has been enacted and being in-serviced to staff on how to interpret results and implement a program to meet the resident needs. The development of a 72 hour bowel and bladder diary will be used consistently as an assessment to ensure accuracy in</p> | | |

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| F 690 | <p>Continued From page 31</p> <p>transient causes of incontinence, the staff will initiate a toileting plan. After a three-day diary is completed to note usual incontinence pattern of resident ...#21. The staff and physician will evaluate the effectiveness of intervention and implement additional pertinent intervention as indicated..."</p> <p>Review of R9 clinical record revealed:</p> <p>R9 was admitted to the facility on 3/26/18 with the following diagnosis: Status Post Hip Fracture, Repeated Falls, Muscle Weakness, Difficulty in Walking, Need for Assistance with Personal Care.</p> <p>Physician Initial Visit notes on 3/27/18 documented GU (genitourinary) assessment as "incontinence?"</p> <p>A 3-Day B & B (Bowel & Bladder) Diary initiated on 3/27/18 was incomplete and showed no data entries for the entire 3-11 shift. Noted missing were 11:00 PM entries on 3/28/18 and 3/29/18.</p> <p>A care plan created on 3/28/18 documented "requires assist for personal care" interventions included "Offer toileting assist prior to initiating ADL (Activities of Daily Living) care ..."</p> <p>Review of the admission MDS assessment dated 4/2/18 documented that R9 had a BIMS (a tool that aids in detecting cognitive impairment) Score of 2 suggesting a severe impairment, was extensive assist of one person for toilet use and personal hygiene; used a walker and wheelchair for mobility; and, was occasionally incontinent of urine.</p> <p>A care plan created on 4/3/18 identifying Urinary Incontinence characterized by inability to control</p> | F 690 | <p>MDS assessments. Urinary continence and incontinence assessment and management policy/procedure has been reviewed/revised to assure urinary continence/incontinence needs are assessed timely and address any potential continence/incontinence need. Policy will be in-serviced to nursing staff. 72 Hour Bowel and Bladder flow sheet document updated. Upon completion of flow sheet appropriate toileting program will be offered.</p> <p>D. Ongoing success will be determined by ensuring compliance with (1) administering bowel/bladder restorative assessment, (2) 72 hour flow sheets are accurately completed, (3) care plans are updated, (4) recommendations for continence management/toileting program are offered and (5) progress is documented for all new residents, readmissions and change of status. Measuring compliance will be achieved by the following measures. (1) DON/ designee audits of bowel and bladder restorative assessment for all current residents daily x 4 weeks to ensure 100% accuracy of recording is achieved. Going forward, DON/designee will audit bowel and bladder assessments once weekly for all new residents/readmission or change of status to ensure 100% compliance. Audits will then be monthly X 3 to ensure 100% compliance and then quarterly on an ongoing basis. (2) DON/ designee audits of 72 hour bowel and bladder flow sheet for all current residents daily x 4 weeks to ensure 100% accuracy of recording is achieved. Going forward, DON/designee will audit 72 hour bowel</p> | | |

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| F 690 | <p>Continued From page 32</p> <p>urination related to Cognitive Deficit and impaired mobility with the goal to be clean, dry and odor free through the review period. Interventions included: Teach resident importance of emptying bladder completely; toilet resident frequently to promote urinary and fecal continence; use verbal reminders to urinate; check for wetness on rounds during the night; and note any changes in amount, frequency, color or odor; Report any abnormalities to Registered Staff.</p> <p>Review of the CNA voiding record from 4/1/18 through 4/30/18 revealed that out of the 90 shifts, R9 had fifty eight (64%) episodes of UC (Urinary Continence) and nine (10%) episode of UI (Urinary Incontinence). Twenty two (24%) shifts had no documentation and no determined continence episodes with one (2%) shift documented "did not void".</p> <p>6/5/18 Nurse Progress Note filed on paper chart documenting continence showed both "Usually continent" and "Incontinent boxes" were checked off. Resident was not on B & B (Bowel & Bladder) Management Program and decision making ability marked as severely impaired.</p> <p>The first quarterly MDS assessment, dated 6/25/18 documented R9 with the same level of severe cognition impairment, and in need of an extensive assist of one person for toilet use and personal hygiene. A decline in urinary continence was noted from occasionally incontinent to frequently incontinent.</p> <p>A quarterly Bowel and Bladder Program Screener was done on 6/28/18 and documented: " ... voided appropriately without incontinence - not always, but at least daily; Ability to get to the BR (bathroom)/transfer to toilet/commode/urinal,</p> | F 690 | <p>and bladder flow sheets once weekly for all new residents/readmission or change of status to ensure 100% compliance. Audits will then be monthly X 3 to ensure 100% compliance and then quarterly on an ongoing basis.</p> <p>(3) DON/ designee will perform ongoing weekly audits of resident care plans to ensure that results, progress and recommendations are documented in residents' care plans until 100% compliance is achieved. Audits will then be monthly X 3 until 100% compliance, then quarterly and will remain in effect permanently.</p> <p>(3) DON/ designee will validate staff training on updated Urinary Continence/Incontinence Program by auditing all current and newly hired nursing staff's record of in-service training & attendance form. This will be monitored quarterly at QAPI.</p> <p>(4) DON/designee will audit residents' participation and progress in appropriate toileting program weekly using the validation checklist (attached). Audits will then be monthly X 3 until 100% compliance, then quarterly and will remain in effect permanently. All results of audits will be reported at the weekly leadership team meeting for 12 weeks. Thereafter, audit results will be reported at the monthly QA meeting for 3 months. Compliance will be monitored on an ongoing basis to 100% compliance. To ensure continued success of compliance with this program quarterly audits will remain in effect permanently and will be reported at the QAPI meetings. QAPI committee will identify trends and make</p> | | |

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| F 690 | <p>Continued From page 33</p> <p>adjust clothing and wipe... with assistance of 1 person; Mental status - alert and oriented; Mentally aware of need to toilet - usually aware of need to toilet ...".</p> <p>Sections of the Bowel and Bladder Screener were inconsistent with the MDS coding of a BIMS of 2.</p> <p>Review of the CNA voiding record from 6/1/18 through 6/30/18 documented that out of 90 shifts, R9 had thirty-six (40%) episodes of urinary continence, twenty-eight (31%) episodes of urinary incontinence and twenty-six (29%) shifts had no documentation and no determined continence episodes.</p> <p>7/15/18 - Nurse Progress Note filed on paper chart documenting continence showed both "Usually continent" and "Incontinent" boxes were checked off. Not on B & B (Bowel & Bladder) Management Program. Decision-making ability marked as "severely impaired". Behavior problem was identified as R9 "gets agitated at intervals and wanted to do him/herself; gets angry when rushed; with 1:1 assist ...".</p> <p>The second quarterly MDS assessment, dated 9/25/18 documented the same level of severe cognition impairment; that R9 was an extensive assist of one person for toilet use and personal hygiene; and frequent urinary incontinence.</p> <p>Review of the September 2018 CNA voiding record form from 9/1/18 through 9/30/18 revealed that of the 90 shifts, R9 had eight (9%) episodes of urinary continence and sixty-two (69%) urinary incontinence across all shifts with twenty (20%) shifts which had no documentation nor determined continence episodes.</p> | F 690 | <p>recommendations based on audit results.</p> <p>Attachments</p> <ol style="list-style-type: none"> 1. Policy & Procedure: Continence Management 2. Training Guide <input type="checkbox"/> Bowel/Bladder Continence Program 3. Record of In-service Training & Attendance <input type="checkbox"/> Bowel/Bladder Continence Program 4. QAPI Audit Form <input type="checkbox"/> Bowel/Bladder Continence 5. Resident Centered Incontinence Care Plan 6. Policy & Procedure: Restorative Nursing Program <p>Corrective action completion date: 4/28/19</p> | | |

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| F 690 | <p>Continued From page 34</p> <p>A Bowel and Bladder Program Screener was done on 12/17/18 and documented: " ... Candidate for Schedule toileting (timed voiding) (R9) voided appropriately without incontinence - never; Ability to get to the BR(bathroom)/transfer to toilet/commode/urinal, adjust clothing and wipe, etc. - with assistance of 1 person; Mental status - has changed to forgetful but follows commands; Mentally aware of need to toilet - sometimes aware of need to toilet..."</p> <p>Review of the subsequent quarterly MDS assessment, dated 12/20/18, revealed the same level of severe cognition impairment; the requirement for an extensive assist of one person for toilet use and personal hygiene; and, frequent urinary incontinence.</p> <p>Review of the December 2018 CNA voiding record form from 12/1/18 through 12/31/18 revealed that, of the 93 shifts, R9 had eleven (12%) episodes of urinary continence and sixty-three (68%) episodes of urinary incontinence. Two (2%) shifts documented both continent and incontinent episodes with seventeen (18%) shifts having no documentation nor determined continence episodes.</p> <p>Review of R9's January 2019 CNA voiding record from 1/1/19 through 1/31/19 revealed that of the 93 shifts, R9 had 72 (77%) episodes of urinary incontinence across all 3 shifts and 7 (8%) episodes of urinary continence with 14 (15%) shifts having no documentation nor determined continence episodes.</p> <p>On 2/21/19 at 10:49 AM - R9's room had a strong urine odor.</p> <p>During the following observations R9 had a urine</p> | F 690 | | | |

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| F 690 | <p>Continued From page 35</p> <p>odor: 2/22/19 at 8:54 AM; 9:16 AM; 2:11 PM and 3:10 PM 2/25/19 at 8:06 AM</p> <p>2/22/19 2:14 PM - An interview with E7 (LPN) stated that "...R9 uses wheelchair (with 1 person assist) now to go to the bathroom - mostly incontinent. Only had he/her voiding diary done when she was admitted in March last year. The CNAs document every shift the urinary continent status."</p> <p>2/22/19 3:08 PM - An interview with E14 (CNA) stated that "...Resident used to be able to get up and go to the bathroom with assistance until she had a fall in October 2018. He's/She's afraid to use the walker so we transfer him/her using the wheelchair when we bring him/her to the bathroom. I usually come in and ask to take him/her to the bathroom between 7-10 AM in the morning then during noon before lunch time and between 2-3 PM before I leave my shift."</p> <p>2/22/19 3:10 PM - Observed E14 (CNA), offering to take R9 to the bathroom. R9 refused saying he/she was just there an hour ago. R9's room still smelled of urine odor specially near the bed and recliner area.</p> <p>2/25/19 8:57 AM - An interview with E13 (LPN) confirmed that "...3 Day Voiding Diary was only done on her admission to the facility in March 2018. Resident is very resistant with care. He/She sometimes do what you ask him/her to do specially getting up to go to the bathroom and having his/her incontinence care done. Uses the toilet to urinate and we always remind him/her many times to use call bell for help in going to the bathroom. Sometimes he/she does what he/she</p> | F 690 | | |

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| F 690 | <p>Continued From page 36</p> <p>wants to do and sits in the recliner and wets him/herself ...We offer to take him/her to the bathroom every 2 hours; sometimes he/she gets up and sometimes not."</p> <p>2/25/19 9:00 AM - E13 (LPN) offered to take R9 to the bathroom to use the toilet. R9 was observed getting up from raised recliner and with E13's limited assistance transferring from recliner to wheelchair and from wheelchair to toilet seat with no difficulty. R9 was instructed by E13 to use the call bell for assistance transferring back to the recliner when done. After 2 minutes, surveyor observed R9 ringing the bathroom call bell and a CNA staff entered the room to assist R9 back to the recliner.</p> <p>2/26/19 10:27 AM - An interview with E10 (CNA) revealed that "Resident had a fall here, and after that he/she stopped walking to the bathroom. He/She rings the bell to ask for her wheelchair to the bathroom. I usually check him/her before breakfast, after breakfast, then after lunch. We do not have a set toileting schedule for him/her. I go by my own time. Sometimes he/she's already soiled so room smells like urine so I take him/her to the bathroom and also change his/her clothes or give him/her a shower."</p> <p>Review of R9's CNA voiding record during the period from 2/1/19 through 2/26/19 showed that of the 78 shifts, R9 had 55 (71%) episodes of urinary incontinence across all 3 shifts and 11 (14%) episodes of urinary continence with 12 (15%) shifts with no documentation nor determined continence episodes.</p> <p>Although the facility records documented a decline in urinary continence from 64% in April to 8% in January 2019, the facility failed to initiate a</p> | F 690 | | | |

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| F 690 | Continued From page 37 person-centered toileting plan. The facility, despite this documented decline, failed to complete and review a three-day voiding diary to note R9's usual incontinence pattern. The facility failed to implement a revised care plan for urinary incontinence when R9 had increasing urinary incontinence episodes from occasionally incontinent in April 2018 to frequently incontinent in June 2018, September 2018 and December 2018 MDS assessments. The facility failed to identify and intervene when a decline in urinary continence was identified; thus, resulting in harm when R9 became more incontinent of urine. 2/28/19 beginning at approximately 4:00 PM - Findings were reviewed with E1 (CEO), E2 (NHA), E3 (DON), and E4 (DOR) during the Exit Conference. | F 690 | | |
| F 756 SS=D | Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical | F 756 | | 4/19/19 |

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| F 756 | <p>Continued From page 38</p> <p>director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.</p> <p>§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and record review, it was determined that the pharmacy failed to identify an irregularity on medication order transcription discrepancies for one (R3) out of 5 sampled residents for medication review. Findings include:</p> <p>Review of R3's clinical record revealed:</p> <p>12/6/18 - R3 was being treated for anxiety and had a Physician Order for Clonazepam (Klonopin) 0.5 mg 1 tab PO (by mouth) twice daily and take ½ tab (0.25 mg) every 12 hours.</p> <p>12/16/18 - Documentation on an Interim Physician Order Sheet, the medication dose and frequency order was changed into Clonazepam 0.5 mg 1 tablet po twice daily for agitation/anxiety.</p> <p>12/29/18 - January 2019 (Monthly) POS ("Physician's Order Sheet") was reviewed by E3</p> | F 756 | <p>A. R3 Clonazepam order will be clarified and fixed and sent to pharmacy to correct discrepancies on Physician Order Sheet (POS), Medication Administration Record (MAR) and order labels in the blister packs. No resident was harmed.</p> <p>B. The Pharmacist will complete a facility audit on medication irregularities and transcription discrepancies to assure discrepancies are recognized and reflected accurately on the MAR, POS, and order labels in the blister packs. If discrepancies are found, the order will be clarified and sent out to pharmacy to correct any irregularities. Pharmacist and licensed nursing staff will be in-serviced on this process.</p> <p>C. Monthly Drug Regimen Review Policy updated to include time frames for different steps in the process and steps</p> | | |

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| F 756 | <p>Continued From page 39 (DON) reflecting the new order for Clonazepam 0.5 mg tab (tablet) Take 1 tab by mouth twice daily for anxiety/agitation.</p> <p>1/14/19 - E21 (Pharmacist) received a Physician Telephone Verbal Order from E8 (Medical Director) for a "New Order: Clonazepam 0.5 mg 1 T (tablet) PO (by mouth) BID (two times a day) ...and... ½ tab (0.25 mg) PO Q (every) 12 H (hours) PRN (as needed)"</p> <p>1/15/19 - E8 (Medical Director) signed the January 2019 POS with the order dated 12/16/18 for Clonazepam 0.5 mg one tablet PO twice daily for agitation/anxiety.</p> <p>1/31/19 - February 2019 (Monthly) POS was reviewed by E3 (DON) indicating the order dated 12/6/18 for Clonazepam 0.5 mg tab (tablet) Take 1 tab by mouth twice daily...and take ½ tablet (0.25 mg) every 12 hours as needed (nurse to reorder) for anxiety. The text "AS NEEDED (NURSE TO REORDER)" was crossed out.</p> <p>2/5/19 - E8 (Medical Director) signed the February 2019 POS with the order dated 12/6/18 for Clonazepam 0.5 mg tab (tablet) Take 1 tab by mouth twice daily...and take 1/2 tablet (0.25 mg) every 12 hours as needed (nurse to reorder) for anxiety with the text "AS NEEDED (NURSE TO REORDER)" crossed out.</p> <p>2/18/19 - R3's MMR (Medication Regimen Review) form completed by E11 (Consultant Pharmacist) stated: "Note clonazepam is a Beers' list medications and carry increased fall risk, monitor closely, consider safer option, if possible (buspirone?)." There was no evidence that E11 recognized the discrepancies on the POS and MAR (Medication Administration Record) from the</p> | F 756 | <p>the pharmacist must make when he/she identifies an irregularity that requires urgent action to protect the resident. Pharmacist and licensed nursing staff will be educated on the Monthly Drug Regimen Review Policy.</p> <p>D. DON/designee will randomly audit the medications of 5 residents weekly and then ongoing monthly in conjunction with the monthly pharmacist review to ensure 100% compliance of any irregularities identified and reflected accurately in MAR, POS and order labels on blister packs. Results of the audit will be reviewed at the regularly held QAAP meeting. Completion date 4/19/19.</p> | | |

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| F 756 | <p>Continued From page 40</p> <p>old to the current Clonazepam orders for R3 when the MRR was conducted.</p> <p>2/26/19 10:30 AM - Review of the February 2019 MAR reflected the order dated on 12/6/18 as, "Clonazepam 0.5 mg tab Take 1 tablet by mouth twice daily...and take ½ tablet (0.25 mg) every 12 hours" (as needed - text was noted manually crossed out)... Medication administration was timed for 9:00 AM and 9:00 PM.</p> <p>2/26/19 10:35 - Further review of the January 2019 and February 2019 MAR lacked evidence of discontinuing the Clonazepam order on 12/16/18 for "0.5 mg 1 tab PO twice a day for anxiety."</p> <p>2/26/19 10:40 AM - Review of the February 2019 PRN Medication flowsheet revealed the order "Clonazepam 0.5 mg tab Take ½ tab = 0.25 mg every 12 hours as needed for increased anxiety" marked as "error and D/C (discontinued) 12/16/18."</p> <p>2/26/18 10:45 AM - Review of the February Medication Card/Blister Pack of the same medication from the med cart revealed the label "Clonazepam 0.5 mg tab Take 1 tablet by mouth twice daily...and take ½ tablet (0,25 mg) every 12 hours ("as needed" - text was NOT manually crossed out)</p> <p>2/26/19 12:10 PM - Interview with E9 (RN) and E7 (LPN) both confirmed that the "active clonazepam order is 0.5 mg 1 tab PO twice daily for agitation and anxiety, and that there is no more PRN orders. The Klonopin 0.5 mg twice a day was not discontinued" E9 and E7 further confirmed that "since this information came from the pharmacy including the labels, the February MAR and the Medication Card/Blister Pack has</p> | F 756 | | | |

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| F 756 | <p>Continued From page 41</p> <p>the wrong label which was based from the old Klonopin order on 12/6/18."</p> <p>2/26/19 12:20 PM - E9 (RN) presented to surveyor a faxed copy from the pharmacy of a Physician Telephone Verbal Order obtained by E21 (Pharmacist) from E8 (Medical Director) for "New Order: Clonazepam 0.5 mg 1 T (tablet) PO (by mouth) BID (two times a day) ...and ... ½ tab (0.25 mg) PO Q (every) 12 H (hours) PRN..." E9 further stated "The pharmacy sent this to me just now. I called them to ask why the Klonopin order on the POS, MAR and blister packs were not right. I really do not know about this. Maybe the Doctor called the Pharmacy directly for this request on 1/14/19 but this was not communicated to us. I don't see this filed in the chart. Nobody knew these orders and labels have been incorrect." It was further noted that the faxed copy of the Physician Telephone Verbal Order on 1/14/19 did not have E8's signature on it.</p> <p>2/26/19 2:20 PM - An interview with E8 (Medical Director) confirmed the discrepancy. Also confirmed that R3 only has the Clonazepam 0.5 mg twice a day only and has no as needed order. E8 further said that "R3's Clonazepam order will be clarified and fixed and send out to Pharmacy as soon as possible to correct the discrepancies on the Physician Order Sheet, Medication Administration Record and Order labels in the blister packs."</p> <p>2:26/19 2:39 PM - Discussed with E3 (DON) and confirmed of the discrepancies with Clonazepam medication order and discrepancy on the medication label in the card/blister pack.</p> <p>The pharmacist failed to recognize during R3's</p> | F 756 | | | |

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| F 756 | Continued From page 42 Medication Regimen Review on 2/18/19 the discrepancies from the old to the current Clonazepam medication order, which was not updated and reflected accurately on the February 2019 Physician Order Sheet, February 2019 Medication Administration Record and the February Medication Card/Blister Pack Label. 2/28/19 beginning at approximately 4:00 PM - Findings were reviewed with E1 (CEO), E2 (NHA), E3 and E4 (DOR) during the Exit Conference. | F 756 | | | |
| F 790 SS=D | Routine/Emergency Dental Srvcs in SNFs CFR(s): 483.55(a)(1)-(5) §483.55 Dental services. The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(a) Skilled Nursing Facilities A facility- §483.55(a)(1) Must provide or obtain from an outside resource, in accordance with with §483.70(g) of this part, routine and emergency dental services to meet the needs of each resident; §483.55(a)(2) May charge a Medicare resident an additional amount for routine and emergency dental services; §483.55(a)(3) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; §483.55(a)(4) Must if necessary or if requested, | F 790 | | 4/19/19 | |

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| F 790 | <p>Continued From page 43</p> <p>assist the resident; (i) In making appointments; and (ii) By arranging for transportation to and from the dental services location; and</p> <p>§483.55(a)(5) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, it was determined that the facility failed to assist a resident/family in making dental appointments and/or transportation arrangements for routine dental services for one (R15) out of three sampled residents for dental services. Findings include:</p> <p>The facility's policy and procedure entitled "Dental Services", with the most recent revision date of 2/2019 indicated that the facility would provide routine and emergency dental services to meet the resident's oral health needs in accordance with the resident's assessment and plan of care. In addition, proper dental care is necessary for residents personal hygiene and oral health.</p> <p>Cross refer F641.</p> <p>Review of R15's clinical record revealed:</p> <p>10/12/17 - R15 was admitted to the facility.</p> <p>10/14/18 - A significant Change MDS assessment failed to include that R15 had missing or broken</p> | F 790 | <p>A. R15 will be offered a Dental appointment and facility will assist in scheduling a dental appointment if accepted. No resident was harmed.</p> <p>B. Facility will offer residents dental services and assist in scheduling dental appointment if accepted.</p> <p>C. Dental Services Policy was reviewed and revised to ensure routine and emergency dental services are provided. Policy will be in-serviced to staff. Dental Services will be offered to residents at regularly held resident care plan meetings.</p> <p>D. DON/designee will audit residents weekly x 3 and then ongoing monthly to ensure dental services are being offered at the regularly held quarterly care conferences to ensure 100% compliance. Results of the audit will be reported at the regularly scheduled QAAP meeting. Completion date 4/19/19</p> | | |

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| F 790 | Continued From page 44 teeth. 12/27/18 - A quarterly MDS assessment failed to include that R15 had missing or broken teeth. 2/21/19 at 2:37 PM - R15 was observed with multiple missing and broken teeth. R15 verbalized she was uncertain when was the last time he/she had routine dental services. R15 denied any problems with chewing, loose teeth, or problems with the gums. 2/27/19 at approximately 2:55 PM - An interview with E10 (CNA) revealed that R15 has had broken teeth for some time. 2/27/19 at approximately 3:00 PM - An interview with E3 (DON) revealed that routine dental services were offered to the residents on a regular basis, which was every 6 months. Record review lacked evidence that R15 was offered routine dental services since admission. 2/27/19 at approximately 7:09 PM - An interview with E12 (LPN), who had spoken with R15's family member confirmed that R15 had not received routine dental services since moving to Delaware, which was prior to the admission to the facility in 10/12/17. The facility failed to assist R15's family member in making a routine dental appointment. 2/28/19 beginning at approximately 4:00 PM - Findings were reviewed with E1 (CEO), E2 (NHA), E3 (DON), and E4 (DOR) during the Exit Conference. | F 790 | | | |
| F 868 | QAA Committee | F 868 | | 4/19/19 | |

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| F 868 SS=F | Continued From page 45 CFR(s): 483.75(g)(1)(i)-(iii)(2)(i) §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; §483.75(g)(2) The quality assessment and assurance committee must: (i) Meet at least quarterly and as needed to identifying issues with respect to which quality assessment and assurance activities are necessary. This REQUIREMENT is not met as evidenced by: Based on review of facility documentation and interview, it was determined that the facility's quality assurance (QA) committee meeting did not include the medical director. Findings include: Review of facility documentation on the quarterly QA meetings revealed the following: 1/24/19 - The quarterly QA meeting sign-in sheet lacked evidence that the E8 (Medical Director) participated. 2/25/19 at approximately 1:45 PM - An interview with E3 (DON) confirmed that E8 was not present for the meeting. The facility's quality assurance committee failed to meet at least quarterly and include the medical director. | F 868 | A. The facility unable to retroactively correct the medical director's attendance at quarterly QAAP meetings. No resident was harmed. B. The facility will conduct a quarterly QAAP meeting with the QA Committee, with the Medical Director. C. Quality Assurance policy has been reviewed/revise to assure facility's team is identifying issues with respect to which quality assessment and assurance activities are necessary. Policy will be in-serviced to QA committee. D. The NHA will attend the quarterly scheduled QAAP meeting to assure that facility maintains a quality assessment and assurance committee including the Medical Director for 4 quarterly meetings and ongoing thereafter. NHA will send an | | |

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| F 868 | Continued From page 46 2/28/19 beginning at approximately 4:00 PM - Findings were reviewed with E1 (CEO), E2 (NHA), E3 (DON), and E4 (DOR) during the Exit Conference. | F 868 | invitation to the Medical Director as a reminder of the upcoming 4 quarterly meetings to ensure attendance. Completion date 4/19/19. | | |
| F 880 SS=E | Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; | F 880 | | 4/28/19 | |

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| F 880 | <p>Continued From page 47</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv) When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and</p> <p>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review, interview, and review of other facility documentation as indicated, it was determined that the facility failed to ensure ensure an effective Infection Prevention and Control Program (IPCP) program. The facility failed to ensure the IPCP program was reviewed annually, including having updated policy and procedures. The facility failed to use proper</p> | F 880 | <p>A. Facility will develop and implement an effective Infection Prevention and Control (IPC) program to reduce/prevent spread of infection. E13 will be educated on proper infection control techniques during medication administration with a return demonstration. No resident was harmed.</p> <p>B. Licensed nursing staff will be</p> | |

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| F 880 | <p>Continued From page 48</p> <p>infection control techniques during medication administration for three (R7, R9 & R12) out of 4 sampled residents for medicaton pass. Findings include:</p> <p>1. Cross refer F883 - The facility failed to ensure residents were offered or had received both pneumococcal vaccinations based on CDC recommendations.</p> <p>Review of the infection control program during the survey lacked evidence of yearly review. The following infection control policies and procedures had not been reviewed in years or contained no date at all. Many of the policies contained the name of the former facility at the same location.</p> <p>Antibiotic Use (1/2014); Influenza Vaccine; Pneumococcal Vaccine (no date on one and the other dated 2/2007); Cleaning and Disinfecting Equipment; Isolation; Discontinuing Isolation; Transmission Based Precautions; Notice of Transmission Based Precautions; Removing a Body from Isolation, Reportable Diseases; Exposure Reporting and Investigating, Needlesticks and Cuts, Exposure Reports; Identifying Healthcare Associated Infections; Quarantine; Diagnostic Service Agreement; Culture Tests; Standard Precautions; Soiled Laundry Handling (1/2013); Medical Waste (1/2010).</p> <p>2/28/19 at 11:28 AM - During an interview with E1 (NHA), it was confirmed that the facility's policies</p> | F 880 | <p>educated on proper infection control technique during medication administration with a return demonstration utilizing the form to ensure accuracy in assessing medicine administration competency.</p> <p>C. Facility will review IPC program at QAPI meetings and then annually. Facility will update and revise the Infection Prevention and Control policies and procedures annually. Facility will in-service staff on Infection Prevention and Control policy and procedure.</p> <p>D. (1) Facility will conduct their annual review of the IPCP Program by 4/28/2019 and update relevant policies and procedures. Thereafter, facility will conduct annual reviews and updates of the IPCP Program, every January. Audits of ongoing compliance for annual review of IPCP will be conducted by the Administrator and reported at quarterly QAPI to ensure 100% compliance. (2) DON will randomly audit two licensed nursing staff weekly until 100% compliance is achieved. Once a period of 4 weeks of 100% compliance is verified, the random audits will take place on an ongoing monthly basis to ensure proper technique for infection control is maintained for Medication Administration. Monthly audits will be conducted for 3 months to ensure 100% compliance, and then will take place on a quarterly basis. To ensure continued success of compliance with this program quarterly audits will remain in effect and will be reported at the QAPI meetings to monitor its performance to make sure that solutions are sustained permanently.</p> | | |

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| F 880 | Continued From page 49 were not all up to date. 2a. During medication administration for R7 on 2/25/18 at 9:00 AM, E13 (LPN) was observed touching the medications with her bare hand as the pills were being popped out from the blister pack into the medicine cup without hand sanitizing or washing her hands. b. During medication administration for R9 on 2/25/18 at 9:10 AM, E13 (LPN) was observed touching the medications with her bare hand as the pills were being popped out from the blister pack into the medicine cup without hand sanitizing or washing her hands. c. During medication administration for R12 on 2/25/18 at 9:20 AM, E13 (LPN) was observed touching the medications with her bare hand as the pills were being popped out from the blister pack into the medicine cup without hand sanitizing or washing her hands. During an interview with E13 (LPN) on 2/25/19 at 9:40 AM, the findings were reviewed and confirmed. The findings were reviewed with E1 (CEO), E2 (NHA), E3 (DON), and E4 (DOR) during the Exit conference beginning at approximately 4:00 PM. | F 880 | Corrective action completion date: 4/28/19 | |
| F 883 SS=E | Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(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; | F 883 | | 4/28/19 |

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| F 883 | <p>Continued From page 50</p> <p>(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;</p> <p>(iii) The resident or the resident's representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:</p> <p>(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and</p> <p>(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.</p> <p>§483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-</p> <p>(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;</p> <p>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;</p> <p>(iii) The resident or the resident's representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:</p> <p>(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and</p> | F 883 | | | |

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| F 883 | <p>Continued From page 51</p> <p>(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 as evidenced by:</p> <p>Based on record review and interview it was determined that for five (R5, R8, R11, R12 and R13) out of 5 residents sampled for immunization review the facility failed to have evidence that residents were offered both pneumococcal vaccines in accordance with CDC (Center for Disease Control) standards. Findings include:</p> <p>Review of the policy "Pneumococcal Vaccine (Pneumovax)" dated 2/2007 documented "Unless otherwise contraindicated, residents are vaccinated every five years...". The policy also included instructions on how to administer and injection and included the Pneumococcal Vaccine fact sheet from the CDC dated 10/6/2009. (last updates on CDS website 4/24/15 and 11/5/15).</p> <p>The facility provided a second undated policy "Pneumococcal Vaccine" that documented "Administration of the pneumococcal vaccination or revaccinations will be made in accordance with current CDC recommendations at the time of the vaccine".</p> <p>CDC recommends pneumococcal vaccination (PCV13 or Prevnar13®, and PPSV23 or Pneumovax23®) for all adults 65 years or older: -Give a dose of PCV13 to adults 65 years or older who have not previously received a dose. Then administer a dose of PPSV23 at least 1 year later. -If the patient already received one or more doses of PPSV23, give the dose of PCV13 at least 1 year after they received the most recent dose of</p> | F 883 | <p>A. Facility will assess R5, R8, R11, R12, R13 pneumococcal vaccination status using CDC Vaccination Assessment Note. Residents will be offered the recommended pneumococcal vaccine per the outcome of the assessment. No resident was harmed.</p> <p>B. Facility will assess current residents and new admissions for pneumococcal vaccination status using CDC Vaccination Assessment Note. Residents will be offered the recommended pneumococcal vaccine per the outcome of the assessment.</p> <p>C. Influenza and Pneumococcal immunizations for residents policy and procedures revised to be in accordance with current CDC recommendations. The licensed nursing staff will be in-serviced on the influenza and pneumococcal vaccinations. Licensed nursing staff will be in-serviced using the CDC assessment for determining pneumococcal vaccination status.</p> <p>D. DON will audit all current residents and any new admissions weekly x 8 weeks and then ongoing monthly to ensure 100% compliance that (1) CDC assessment for determining pneumococcal vaccination status is utilized (2) Residents are offered both pneumococcal vaccines in accordance with CDC recommendations. (3) Mandatory in-service for all nursing staff</p> | |

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| F 883 | <p>Continued From page 52 PPSV23. https://www.cdc.gov/vaccines/vpd/pneumo/hcp/recommendations.html</p> <p>The following residents were reviewed and noted to have a pneumococcal vaccination:</p> <p>R12 - 10/10/18 R8 - 1/1/11 R13 - 9/19/16 R11 - 7/9/18 R5 - 3/5/15</p> <p>There was no evidence that the above residents had or were offered both PPSV13 and PPSV23.</p> <p>2/28/19 11:28 AM - During an interview with E1 (NHA) it was confirmed that the facility's policy was not updated to include PCV13 and PPSV23.</p> <p>2/28/19 beginning at approximately 4:00 PM - Findings were reviewed with E1 (CEO), E2 (NHA), E3 (DON), and E4 (DOR) during the Exit Conference.</p> | F 883 | <p>on updated F883 policy and procedures will be audited by attendance sheets. (4) Document there is a signed consent form stating resident was provided with risk/benefits of pneumococcal vaccination and either consented or declined. Results of these audits will be reviewed quarterly at QAPI. To ensure continued compliance, quarterly audits will remain in effect permanently and will be reported at QAPI meetings.</p> <p>Attachments:</p> <ol style="list-style-type: none"> 1. F883 Policy and Procedures 2. Training and Practice Guidelines for Immunization 3. Validation Checklist for F883 4. In-service Training and Attendance Form <input type="checkbox"/> F883 5. QAPI Audit Form <input type="checkbox"/> F883 6. Annual Influenza Vaccine Consent Form 7. CDC assessment for determining pneumococcal vaccination status <p>Corrective action completion date: 4/28/19.</p> | | |



DELAWARE HEALTH AND SOCIAL SERVICES

Division of Health Care Quality

Office of Long Term Care Residents Protection

DHSS - DHCQ
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: Weston Senior Living at Highfield

DATE SURVEY COMPLETED: February 28, 2019

| SECTION | STATEMENT OF DEFICIENCIES Specific Deficiencies | ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES | COMPLETION DATE |
|---|--|--|-----------------|
| <p>3201</p> <p>3201.1.0</p> <p>3201.1.2</p> | <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 from 2/21/19 through 2/28/18. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census the first day of the survey was 15. The survey sample size was 16.</p> <p>Abbreviations / definitions used in this report are as follows:</p> <p>CEO - Chief Executive Officer; CNA - Certified Nurse's Aide; DON - Director of Nursing; LPN - Licensed Practical Nurse; MD - Medical Doctor; NHA - Nursing Home Administrator; OT - Occupational Therapy; PTA/L - Physical Therapy Assistant/Licensed; RN - Registered Nurse;</p> <p>Regulations for Skilled and Intermediate Care Facilities</p> <p>Scope</p> <p>Nursing facilities shall be subject to all applicable local, state and federal code requirements.</p> | <p>Dementia Training</p> <p>[A] Immediate action was to compile all records for safekeeping and ensure that the roster sheet accurately reflects the present-day staff providing care at the facility.</p> <p>[B] The facility audited the Dementia Training roster list handed out during State Survey and discovered that 3 employees were never employed at the facility E17, E18, E19. Two employees who received Dementia training not previously marked as having received it were E12 and E20.</p> <p>[C] Facility is in compliance</p> <p>[D] Effective immediately, DON/designee initiated random audits on employee files to ensure compliance with training requirements. 5 employee files will be reviewed per week for 8 weeks until all employee charts have been reviewed. Audit will continue until 100% compliance will be verified. Results will be presented at monthly QA meetings.</p> <p>Nursing Staffing Deficiency</p> <p>[A] No resident was harmed as a result of this alleged deficiency. Immediate action was to analyze the facility's staffing methodology when it comes to placement of RN's on every shift, particularly on Night shift.</p> <p>[B] All residents were asked if they were affected on the five dates in question: 2/3, 2/6, 2/9, 2/11, 2/13. No one remembered being affected or having any less care than any other day.</p> <p>[C] The root cause of this deficiency is staff calling out late, which limits a facility of this size in getting RN's with little notice. Facility was able to get LPN's to work on those corresponding shifts. This is a small center and there not a lot of extra staff to fill in every time staff calls out sick. The Administrative Assistant responsible for staffing was diligently educated by NHA on the requirements for staffing in Long Term Care.</p> <p>[D] Highfield keeps two nurses and one CNA for days and nights and one CNA for evening along with one nurse for over nights for its current census of 16 people. These numbers produce a 4.0 if the health care unit maintains its census of 16 residents. By adding another CNA, the PPD would increase to 4.2 if the facility's census reached its maximum capacity of 19</p> | |

Provider's Signature *E. J. Martin* Title NHA Date 4/1/19



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STATE SURVEY REPORT

NAME OF FACILITY: Weston Senior Living at Highfield

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| | <p>This requirement is not met as evidenced by: Cross Refer to the CMS 2567-L survey completed February 28, 2019: F585, F607, F608, F609, F610, F641, F656, F657, F677, F688, F690, F756, F790, F868, F880, and F883.</p> | <p>residents. All prospective nursing scheduling will be authorized by the DON and NHA for final approval before the schedule is posted at the facility for staff. All shifts are now adequately staffed and facility is now in compliance with Eagle's Law.</p> | |
| 3201.5 | Personnel Administrative | | |
| 3201.5.6 | Dementia Training | | 4/1/19 |
| 3201.5.6.1 | <p>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 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.</p> <p>Based on interview and review of other facility documentation, it was determined that the facility failed to provide dementia specific training in the past year to five (E12, E17, E18, E19, and E20) out of 12 randomly selected healthcare providers reviewed. Findings include:</p> <p>2/25/19 at 11:10 AM – An interview with E1 (CEO) and E2 (NHA) confirmed, for the rehabilitation staff E17 (PTA), E18 (OT), and E19 (OT) which are agency staff, the facility failed to have evidence of dementia training.</p> | | |

Provider's Signature

Bruce Matthews

Title

NHA

Date

4/1/19



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2/28/19 at 3:00 PM – An interview with E1 (CEO) confirmed the facility failed to have evidence of dementia training for E12 (LPN) and E20 (Housekeeping Staff).

2/28/19 beginning at approximately 4:00 PM - Findings were reviewed with E1 (CEO), E2 (NHA), E3 (DON), and E4 (DOR) during the Exit Conference.

The OLTCRP conducted a recertification and complaint survey at the above provider (hereafter referenced as Weston). Entry and exit occurred on 21 February 2019 and 28 February 2019 respectively. As part of this visit, three (3) weeks of facility staffing were reviewed to verify compliance with Delaware Nursing Home Staffing Laws, commonly known as Eagles' Law. The period of 27 January, 2019 through 16 February 2019, inclusive, was checked. The completed OLTCRP Staffing Worksheets were signed by the Facility Administrator.

The **FIVE (5)** citations below result from that work.

16 Del. C., 1161 Nursing Staffing:

(f) There shall be a Nursing Supervisor on duty and on site at all times.

Nursing Supervisor shall mean an Advanced Practice Nurse or Registered Nurse who is assigned to supervise and evaluate nursing services direct caregiver-

4/1/19

Provider's Signature Bruce Montemary Title NHA Date 4/1/19



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| | <p>ers no less than 25 percent of the Nursing Supervisor's time per shift.</p> <p>An individual serving as a Nursing Supervisor must be an employee of the facility, thus excluding temporary employment agency personnel from serving in this capacity unless Exigent Circumstances exist.</p> <p>The term "Exigent Circumstances" means a short-term emergency or other unavoidable situation, and all reasonable alternatives to the use of either a temporary employee or a nurse of lesser than Registered Nurse designation have been exhausted.</p> <p>Within 24 hours of the Exigent Circumstances that require the use of temporary employment agency staffing to fill a Nursing Supervisor position in a residential health facility, the facility shall notify the Division in writing of the Exigent Circumstances and the expected duration.</p> <p>The law was not met as evidenced by:</p> <p>A review of the Staffing Worksheets revealed that Weston failed to have a Registered Nurse on duty, rendering direct resident care, on the following FIVE (5) dates and shifts.</p> <ol style="list-style-type: none"> 1. Sunday, 3 February 2019, Night Shift 2. Wednesday 6 February 2019, Night Shift. 3. Saturday, 9 February 2019, Night Shift. | | <p style="text-align: right;">4/1/19</p> |

Provider's Signature Bruce Martus Title JHA Date 4/1/19



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NAME OF FACILITY: Weston Senior Living at Highfield
SECTION

DATE SURVEY COMPLETED: February 28, 2019
ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES **COMPLETION DATE**

STATEMENT OF DEFICIENCIES
Specific Deficiencies

- 4. Monday, 11 February 2019, Day Shift.
- 5. Wednesday, 13 February 2019, Day Shift.

4/1/19

Provider's Signature Bruce Matthews Title NHA Date 4/1/19