STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	085009		C 02/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOKE COURT SKILLED CENTER AT MANOR HOUSE	1001 MIDDLEFORD ROAD SEAFORD, DE 19973

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced annual and complaint survey was conducted at this facility from February 11, 2019 through February 19, 2019. The facility census the first day of the survey was 54. During this period an Emergency Preparedness Survey was also conducted by the State of Delaware's Division of Health Care Quality Long Term Care Residents Protection in accordance with 42 CFR 483.73. For the Emergency Preparedness survey no deficiencies were cited.	E 000		
F 000	INITIAL COMMENTS An unannounced annual and complaint survey was conducted at this facility from February 11, 2019 through February 19, 2019. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 54. The number of sampled residents with investigative areas totaled 18 residents. Abbreviations used in this report are as follows: NHA - Nursing Home Administrator; DON - Director of Nursing; ADON - Assistant Director of Nursing; RN - Registered Nurse; LPN- Licensed Practical Nurse; CNA - Certified Nurse's Aide; RNAC - Registered Nurse Assessment Coordinator; SW - Social Worker; MD - Medical Doctor;	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/20/2019

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

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F 000	Continued From page 1 1:1 supervision - one staff person assigned direct supervision of a resident; Abnormal Involuntary Movement Scale (AIMS) - test to measure body movements the resident cannot control, side effect of antipsychotic medications; Antibiotic - drug to treat bacterial infection; Antidepressant - drug to treat depression (e.g., duloxetine/Cymbalta); Antipsychotic - drug to treat psychosis and other mental/emotional conditions (e.g.,Seroquel); Anxiotytic - medication to treat feeling of nervousness, worry; BIMS (Brief Interview for Mental Status) - test to measure thinking ability with score ranges from 00 to 15. 13-15: Cognitively intact 08-12: Moderately impaired 00-07: Severe impairment Bipolar - mood disorder causing fluctuation between feeling down and feeling elevated; Cognitive impairment - decreased ability to think, makes poor decisions and requires supervision; Dementia - a brain disorder with memory loss, poor judgement, personality changes and disorientation; e.g.- such as; Dialysis / Hemodialysis - cleansing of the blood by artificial means when kidneys have failed; Dialysis catheter - tube in a large vein in chest so dialysis can be performed; Dialysis shunt - tube inside the arm so dialysis can be performed; eMAR - Electronic Medication Administration Record (in the computer); Extensive Assistance - resident involved in activity, staff provide weight-bearing support; I&D (Incision and Drainage) - a minor surgical procedure to release pus or pressure built up under the skin, such as from an abscess or boil;	F 000		

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F 000	Continued From page 2 Lesion - wound or sore; Limited Assistance - resident highly involved in activity, staff provide guided movement of limbs or other non-weight bearing assistance; Mania / Manic - abnormal mental state with feeling elevated, racing thoughts, risk taking and irritability; MDS (Minimum Data Set) - standardized assessment used in nursing homes; MRSA (Methicillin-Resistant Staphylococcus Aureus) - antibiotic-resistant bacteria/bacteria that is hard to eliminate; Multi-drug resistant organisms ("MDRO") - common bacteria (germs) with resistance (does not eliminate) to many antibiotics; PASSR (Preadmission Screening and Resident Review) - screening for signs of serious mental illness and/or intellectual disabilities, developmental disabilities or related conditions so if in a nursing home they receive all necessary services for their condition; Pemphigoid / Pemphigus - rare disorder causing large, fluid-filled blisters; Psychiatric - related to mental disorders; Psychiatrist - physician for treatment of mental disorders; Rehabilitation - treatment for recovery from injury or disease.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each	F 550		4/12/19

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F 550	Continued From page 3 resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, it was determined that the facility failed to ensure that staff provided a dignified dining experience for two (R23 and R31) residents randomly observed in the dining room. Findings include: 2/12/19 - During a random lunch observation in the dining room serving residents who required	F 550	F 550 - D Disclaimer Statement: Preparation and/or Correction does not constitute admission or agreement of the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction of prepared and/or executed solely because	

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F 550	Continued From page 4 assistance with meals: 1. At 12:05 PM, E18 (CNA) was observed behind R23 placing a cloth clothing protector around his/her neck with out speaking to the resident and causing R23 to be startled. 2. At 12:15 PM, E19 (CNA) was observed placing a cloth clothing protector around R31's neck with out speaking to this resident. This finding was reviewed with E1 (NHA), E2 (DON) and E3 (ADON) on 2/19/19 during the exit conference beginning at 4:00 PM.	F 550	it is required by the provisions of federal and state law. this plan represents the facility's credible allegation of compliance as of 4/12/2019 F 550 S/S D A1: The Social Worker interviewed resident R23 to see if she had any Psychological Social or Traumatic residual from the issue. The Social Worker talked with the POA and explained the issue with them. The POA was fine and said they did not notice any issues with R23 resulting from the issue. Staff in the dining room were notified of the issue and educated to the proper way of putting a clothing protect on a resident. B2: Any residents that wear a clothing protector is at risk for the same issue. The Social Worker has interviewed each of the resident's that wear clothing protector. The Social Worker found no complaints from any of the other residents regarding this issue. C1: The issue occurred because the staff know the resident's so well and knows who wants a clothing protector. In many cases the resident is a sleep when the staff puts the clothing protector on. Staff did not notice who was up or who was alert when they put the protector on. Anyone that likes a clothing protector will have one at the table when they arrive. The staff will ask and explain why they are slowly putting the around the resident's neck. Staff will wake anyone up and make sure they are aware of what is happening before doing anything. CNAs and Licensed staff will be educated via mandatory in-services on the proper	

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F 550	Continued From page 5	F 550	process of placing a clothing protector on the resident and why the process is necessary. D1: This will be audited three days per week by a nurse, NHA or DON/designee until 100% compliance is reached. Then audit will be done 1 time per week to ensure 100% compliance is maintained. Then the audits will be done 1 time per month to ensure 100% compliance is maintained. All Audits will be reported to QA each month for three months to maintain 100% compliance. A2: The Social Worker interviewed resident R31 to see if she had any Psychological Social or Traumatic residual from the issue. The Social Worker talked with the POA and explained the issue with them. The POA was fine and said they did not notice any issues with R31 resulting from the issue. Staff in the dining room were notified of the issue and educated to the proper way of putting a clothing protect on a resident. B2: Any residents that wear a clothing protector is at risk for the same issue. The Social Worker has interviewed each of the resident's that wear clothing protector. The Social Worker found no complaints from any of the other residents regarding this issue. C2: The issue occurred because the staff know the resident's so well and knows who wants a clothing protector. In many cases the resident is a sleep when the staff puts the clothing protector on. Staff did not notice who was up or who was alert when they put the protector on. Anyone that likes a clothing protector will	

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F 550	Continued From page 6	F 550	have one at the table when they arrive. The staff will ask and explain why they are slowly putting the around the resident's neck. Staff will wake anyone up and make sure they are aware of what is happening before doing anything. CNAs and Licensed staff will be educated via mandatory in-services on the proper process of placing a clothing protector on the resident and why the process is necessary. D2: This will be audited three days per week by a nurse, NHA or DON/designee until 100% compliance is reached. Then audit will be done 1 time per week to ensure 100% compliance is maintained. Then the audits will be done 1 time per month to ensure 100% compliance is maintained. All Audits will be reported to QA each month for three months to maintain 100% compliance. DON/Designee - April 12 2019	
F 571 SS=D	Limitations on Charges to Personal Funds CFR(s): 483.10(f)(11)(i)-(iii) §483.10(f)(11) The facility must not impose a charge against the personal funds of a resident for any item or service for which payment is made under Medicaid or Medicare (except for applicable deductible and coinsurance amounts). The facility may charge the resident for requested services that are more expensive than or in excess of covered services in accordance with §489.32 of this chapter. (This does not affect the prohibition on facility charges for items and services for which Medicaid has paid. See §447.15 of this chapter, which limits participation in the Medicaid program to providers who accept, as payment in full, Medicaid payment plus any	F 571		4/12/19

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F 571	Continued From page 7 deductible, coinsurance, or copayment required by the plan to be paid by the individual.) (i) Services included in Medicare or Medicaid payment. During the course of a covered Medicare or Medicaid stay, facilities must not charge a resident for the following categories of items and services: (A) Nursing services as required at §483.35. (B) Food and Nutrition services as required at §483.60. (C) An activities program as required at §483.24(c). (D) Room/bed maintenance services. (E) Routine personal hygiene items and services as required to meet the needs of residents, including, but not limited to, hair hygiene supplies, comb, brush, bath soap, disinfecting soaps or specialized cleansing agents when indicated to treat special skin problems or to fight infection, razor, shaving cream, toothbrush, toothpaste, denture adhesive, denture cleaner, dental floss, moisturizing lotion, tissues, cotton balls, cotton swabs, deodorant, incontinence care and supplies, sanitary napkins and related supplies, towels, washcloths, hospital gowns, over the counter drugs, hair and nail hygiene services, bathing assistance, and basic personal laundry. (F) Medically-related social services as required at §483.40(d). (G) Hospice services elected by the resident and paid for under the Medicare Hospice Benefit or paid for by Medicaid under a state plan. (ii) Items and services that may be charged to residents' funds. Paragraphs (f)(11)(ii)(A) through (L) of this section are general categories and examples of items and services that the facility may charge to residents' funds if they are requested by a resident, if they are not required to achieve the goals stated in the resident's care plan, if the facility informs the resident that there	F 571		

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F 571	Continued From page 8 will be a charge, and if payment is not made by Medicare or Medicaid: (A) Telephone, including a cellular phone. (B) Television/radio, personal computer or other electronic device for personal use. (C) Personal comfort items, including smoking materials, notions and novelties, and confections. (D) Cosmetic and grooming items and services in excess of those for which payment is made under Medicaid or Medicare. (E) Personal clothing. (F) Personal reading matter. (F) Gifts purchased on behalf of a resident. (H) Flowers and plants. (I) Cost to participate in social events and entertainment outside the scope of the activities program, provided under §483.24(c). (J) Non-covered special care services such as privately hired nurses or aides. (K) Private room, except when therapeutically required (for example, isolation for infection control). (L) Except as provided in (e)(11)(ii)(L)(1) and (2) of this section, specially prepared or alternative food requested instead of the food and meals generally prepared by the facility, as required by §483.60. (1) The facility may not charge for special foods and meals, including medically prescribed dietary supplements, ordered by the resident's physician, physician assistant, nurse practitioner, or clinical nurse specialist, as these are included per §483.60. (2) In accordance with §483.60(c) through (f), when preparing foods and meals, a facility must take into consideration residents' needs and preferences and the overall cultural and religious make-up of the facility's population. (iii) Requests for items and services. (A) The facility can only charge a resident for any	F 571		

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F 571	Continued From page 9 non-covered item or service if such item or service is specifically requested by the resident. (B) The facility must not require a resident to request any item or service as a condition of admission or continued stay. (C) The facility must inform, orally and in writing, the resident requesting an item or service for which a charge will be made that there will be a charge for the item or service and what the charge will be. This REQUIREMENT is not met as evidenced by: Based on record review, interview and observation it was determined that the facility imposed a charge for a covered service against the personal funds for one (R1) out of 18 sampled residents for investigations. For R1 the facility had the family pay out of pocket for nursing services for 1:1 supervision 24 hours a day while the resident's stay was covered by Medicare. Findings include: Review of R1's clinical record revealed: 1/25/19 - Admission to facility from assisted living after hospitalization for repair of an infected dialysis shunt. R1 had a temporary dialysis catheter through the right side of his/her chest for dialysis which disqualified R1 from returning to assisted living section of the continuous care community, where R1 was "private pay." The resident was using Medicare benefits for the nursing home stay for antibiotics to be given in the vein and monitoring of the dialysis shunt surgical site. 1/27/19 - A care plan for impaired cognitive function contained interventions including: Administer my medications as ordered ; Use my preferred name when speaking to me; Cue,	F 571	F- 571 S/S D Disclaimer Statement Preparation and/or Correction does not constitute admission or agreement of the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of correction of prepared and/or executed solely because it is required by the provisions of federal and state law. This plan represents the facility□s credible allegation of compliance as of 4/12/2019 F - 571 S/S D A. Restoration in full is being made to the family who has been paying for the care giver. B. Residents that have been on Medicare A will be reviewed to ensure they were not charged for items the facility should have been paying for. If any funds need to be refunded this will be done. C. The RCA of this was because the resident, R1, is a private pay resident in the memory care unit at Manor House. When he came to the skilled nursing facility money issues were kept the same	

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F 571	Continued From page 10 reorient and supervise me as needed; Provide me with a homelike environment as much as possible. 1/28/19 - A care plan for history of attempts to leave facility unattended due to impaired safety awareness included a goal that R1 will remain in a safe, supervised environment. Interventions: wanderguard to left ankle [alerts staff when near an exit]; provide structured activities. 2/12/19 (1:43 PM) An interview with F1 (R1's daughter) who explained it was frustrating "that he needs a sitter all the time. . . it is a financial cost to the family." F1 added the family provided for 1:1 supervision from 7:00 PM - 7:00 AM in assisted living. "Within 2 days of being in the health center [the facility] they called and said we need to cover [1:1 supervision with a sitter] 24 hours "since they can't follow him around" and "don't have enough staff." 2/15/19 (around 3:30 PM) - An interview with E2 (DON) revealed that R1 had sitter 24 hours a day paid for by R1's family. This finding was reviewed with E1 (NHA), E2 (DON), and E3 (ADON) on 2/19/19 at the exit conference beginning at 4:00 PM.	F 571	and the family was charged as they were when he was in the memory care unit was only 7a □ 7p. When R1 came to Willowbrooke Court the time was extended due to Willowbrooke not being a secure unit as the memory care unit is. The family will be reimbursed the money spent while in Willowbrooke Court. Residents that are private pay in another section of the facility that come to Willowbrooke court as a Medicare A resident will be reviewed for any items they are paying for. The payment of any items being paid for privately by the resident will be transferred to be paid for the by facility. Any resident that has paid privately in another part of the facility that came to Willowbrooke Court in the past will be reviewed for items they paid for that should have been paid for by the facility. Social Services, MDS, Nursing Management, and the NHA of Willowbrooke Court will be educated on the correct procedure of Medicare A. The education will include the payment method and who pays for what when the resident is a Medicare A recipient. D. Medicare A residents that come from the community will be audited three times per week to ensure no inappropriate charges are leveed against the resident until 100% compliance is reached for three consecutive audits. Then the residents will be audited 1 time per week to ensure 100% compliance is maintained. Then the resident will be audited 1 time per month to ensure compliance maintains 100% compliance. All audits will be brought to QA for review.	

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F 571	Continued From page 11	F 571		
			NHA/ Designee 4/12/2019	
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 the facility failed to enter a discharge MDS assessment for one (R2) out of 19 sampled residents for investigations and resident assessment. Findings include: 1. Review of R2's clinical record revealed: 6/9/18 - Admission to facility for rehabilitation. 7/12/18 - Rehabilitation ended and R2 became long term care. 9/15/18 - Quarterly MDS assessment completed. 9/28/18 - Discharge home with home services. No discharge MDS entry. 2/15/19 (around 4:40 PM) - An interview with E1 (DON) confirmed the missing discharge assessment. This finding was reviewed with E1 (NHA), E2 (DON), and E3 (ADON) on 2/19/19 at the exit conference beginning at 4:00 PM.	F 641	F 641 - SS D Disclaimer Statement Preparation and/or Correction does not constitute admission or agreement of the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of correction of prepared and/or executed solely because it is required by the provisions of federal and state law. This plan represents the facility□s credible allegation of compliance as of 4/12/2019 F641 SS D A. The MDS has been completed for R2 while the survey team was in the facility for the annual survey. B. Any resident who discharges from Willowbrooke Court has the potential to have a missed discharge assessment. C. The RCA of this issue was a system error. PCC did not work and that caused the issue. Everything was done by the MDS coordinator however the system did not take the MDS order. After a review of the policy and procedure we find there is no need for a new policy, procedure, or education for this issue.	4/12/19

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F 641	Continued From page 12	F 641	D. Future Discharges will be reviewed by the DON or designee to ensure the MDS completes in PCC. Discharges will be reviewed daily in morning meeting to ensure discharge MDS are done in a timely manner until 100% compliance is reached. Than all discharges will be reviewed 1x per week to ensure compliance is maintained at 100%. Then all discharges will be audited 1x per month to ensure compliance is maintained at 100%. All audits will be brought to QA for review DON/Designee 4/12/2019	
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review, observation and	F 644	F644 SS D	4/12/19

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F 644	Continued From page 13 interview it was determined that the facility failed to incorporate the PASRR level II (two) recommendations into the care plan for one (R24) out of 18 residents with investigative areas. For R24, the facility failed to review the PASRR level II prior to admission and failed to ensure a psychiatrist or psychiatric nurse practitioner evaluated / adjusted R24's psychiatric medications. Findings include: Cross Refer F656, Example 2. Review of R24's clinical records revealed: 11/8/18 - Completion of PASRR Assessment at the hospital that treated R24 for a suicide attempt determined PASRR level II was required. R24 had a long history of bipolar disorder and depression, and within the past year, bleeding in the brain after a fall. 11/20/18 - The PASRR level II was sent to the hospital and should have followed the resident from facility to facility (verified with PASRR Manager 2/20/19 at 9:45 AM). The specialized services for R24 included that the resident "needs to be seen by a psychiatrist or psychiatric nurse practitioner to evaluate and review her medications. If appropriate she is to be offered supportive therapy to help her deal with her medical issues and changes in her life. This is to be provided by a licensed mental health professional." 12/4/18 - Admission MDS assessment at another facility documented the resident was cognitively intact with a BIMS of 15 out of 15. 12/11/18 - Admission to facility for possible long term care after receiving rehabilitation in a different nursing facility that started 11/20/18.	F 644	Disclaimer Statement Preparation and/or Correction does not constitute admission or agreement of the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of correction of prepared and/or executed solely because it is required by the provisions of federal and state law. This plan represents the facility□s credible allegation of compliance as of 4/12/2019 F 644 - SS D A. R24 continued to receive care and services. Examined by neuropsychology, Psychology. R24 was also evaluated by Psychiatry in an inpatient center. R24 currently resides in the community, participates in activities and is stable on medications. Resident has scheduled appointments with outside psychiatrist and is being followed by in house Psych NP. B. Referrals for admission to the community with mental health diagnosis and PASSAR II have the potential to be affected. C. The RFA was found to be not reviewing the referral as closely to see the needs of the resident and the facility□s ability to care for the resident properly. System changes will be put into place to have SW and nursing administration review all referrals. Questionable admissions will be reviewed with the PASARR unit. If a level two is required, the recommendations will be reviewed for care and services. RCA of deficient practice was lack of communication between discharging community and current admitting	

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F 644	Continued From page 14 Review of R24's care plan found: - 12/13/18: A care plan for psychotropic medications related to bipolar disorder, depression included an intervention (entered 1/28/19) about a psychiatric appointment on 1/29/19 for an assessment to determine cognitive functioning. The care plan did not include a medication evaluation / review by a psychiatrist or a psychiatric nurse practitioner. - 1/15/19: A care plan for verbal aggression related to ineffective coping skills, mental / bipolar disorder, poor impulse control included the intervention for psychiatric . . . consult as indicated. - 1/15/19: A care plan for physical aggression related to anger, dementia, depression, poor impulse control included the same intervention for psychiatric . . . consult as indicated. 12/17/18 - Admission MDS assessment documented the resident had moderate cognitive impairment with a BIMS of 8 out of 15. 2/18/19 (12:30 PM) - During an interview with E8 (SW), E8 acknowledged the PASRR level II recommendations should be reviewed prior to admission to determine if the facility could meet the resident's needs. E8 confirmed R24's PASRR level II document was not reviewed before admission and that it was not identified until 1/8/19 (date on the faxed copy of the PASRR level II assessment) that the facility did not have a copy of the document. E8 stated that R24 had been seen by a psychologist a few times at the facility but R24 decided to be seen across the street at [name of counseling service] for continuing supportive therapy. R24 often changed his/her mind, first saying yes to a psychologist / mental health counselor, then	F 644	community. Paperwork was not reviewed as a team, PASARR was not sent with resident. SW discovered missing level two PASARR while conducting a self-audit for PASARR. The PASARR unit was contacted immediately by SW and this was received and placed on the chart without notifying Nursing Administration for review of the recommendations. Admission team will be educated concerning the purpose of level two PASAR and when they are necessary. D. Audits will be conducted weekly x4, then monthly on residents PASARR□s to determine need for Level 2, any changes, or follow through. This will be reviewed during quarterly QA meetings with the QA team. DON or Designee 4/12/2019	

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F 644	Continued From page 15 rejecting the same. There was no evidence that R24 was ever seen by a psychiatrist or psychiatric nurse practitioner as required by the PASRR level II determination decision. 2/16/19 (11:52 PM) - Nursing progress note documented "This evening shift, resident [name] has been disgruntled, stating she feels as though she would explode. States she has bipolar disorder . . . and she isn't on the right medications. Looked at her meds for tonight and . . . {R24] states that none of these meds work, and she wanted something else, 'right now' . . . at 20:30 [8:30 PM] a call was placed to [name of doctor] . . . would not increase doses of Cymbalta (antidepressant) or Seroquel (antipsychotic) . . . [the doctor] agreed to a one time dose of Ativan 0.5 mg if [R24] would take it." 2/17/19 (10:30 AM) - Nursing progress note documented "Resident came to me this am [morning], c/o [complained of] feelings of being in the manic phase of bipolar disorder. Stated she felt her medications were not correct. I thoroughly reviewed her medications, we [resident name] and I called her pharmacy that she filled her prescriptions with prior to living at [name of facility]. Per the Pharmacist at the [name of pharmacy] in [town and State], [resident name] was taking [Cymbalta] 60 mg po [orally] daily. . . consulted [name of doctor], informed him of the difference, he then ordered an increase in the [Cymbalta]." 2/19/19 (9:25 AM) - An observation of E12 (LPN) attempting to give R24 morning medications in the common area by the nursing station which the resident refused. R24 stated "I need someone to	F 644		

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F 644	Continued From page 16 talk to. Someone competent." E12 informed R24 to let the nurse know when R24 was willing to take the medicine. R24 looked upset and walked in the hallway toward his/her room but promptly returned to the common area by the nursing station. 2/19/19 (9:33 AM) - An observation of R24 talking to E9 (LPN): R24 said "I am depressed and want to talk with someone." E9 responded that she would inform the resident's nurse E12 (LPN). R24 sat down on a chair in the lounge area. 2/19/19 (9:35 AM) - An interview with E9 (LPN) revealed that the nurse heard R24 tell nursing staff that s/he wanted to "jump out the window." E9 stated s/he would "go and pull someone out of morning meeting" now while R24 remained seated in the common area. 2/19/19 (around 9:39 AM) - E2 (DON) was observed approaching R24 and walking with the resident, while talking [1:1 supervision initiated]. 2/19/19 (around 10:15 AM) - An observation of E1 (NHA) escorting R24 off the unit while providing 1:1 supervision. 2/19/19 (around 11:00 AM) - Interview with E2 (DON) who stated that the local psychiatric hospital would not evaluate the resident in the facility. E2 added that s/he did not want to send R24 to the local emergency room since the resident might be there for hours which would not benefit R24. E2 added that the admission coordinator at a psychiatric hospital in another county would be contacted. 2/19/19 (untimed) - An unknown facility CNA assumed 1:1 supervision.	F 644		

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F 644	Continued From page 17 On 2/19/19 (4:00 PM) - R24 was transferred to a psychiatric hospital in another county for inpatient treatment of depression and suicidal thoughts [time verified with E2 (DON) on 2/22/19]. There was no evidence in the record that a psychiatric medication evaluation / review was ever performed while R24 was in the facility as recommended in the PASRR level II determination decision assessment. This finding was reveiwed with E1 (NHA), E2 (DON) and E3 (ADON) on 2/19/19 during the exit conference beginning at 4:00 PM.	F 644		
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 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	F 656		4/12/19

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F 656	Continued From page 18 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: Based on record review and interview it was determined that the facility failed to ensure the comprehensive care plan included required services / treatment to meet the dialysis and mental health needs of two (R1 and R24) out of 18 residents sampled for investigations. Findings include: Cross Refer F698. 1. Review of R1's clinical record revealed: 1/25/19 - Admission to facility with a dialysis catheter through the chest since R1 had surgery on the dialysis shunt in the arm. 1/27/19 (7:32 AM) - A nursing note documented "resident pulled off dressing" over catheter, "opened stat lock (device to secure catheter in place) and was pulling on catheter."	F 656	F 656 SS D Disclaimer Statement Preparation and/or Correction does not constitute admission or agreement of the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of correction of prepared and/or executed solely because it is required by the provisions of federal and state law. This plan represents the facility□s credible allegation of compliance as of 4/12/2019 F 656 SS D A1. R1. Care plan has been updated by RNAC to include emergent care of ASH catheter as per direction of (Dialysis Center). ASH catheter remains securely sutured and all individual clamps remain	

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F 656	Continued From page 19 1/27/19 - A care plan for hemodialysis (dialysis) included intervention to not touch the catheter used for dialysis. The care plan did not include emergent care of catheter in event of dislodgement or breakage. 2/15/19 (11:00 AM) - An interview with E9 (LPN) to review care / treatment in case the dialysis catheter breaks above the clamp on the tubing. E9 searched the medication carts on the nursing unit and both medication room for the "plastic blue clamps" and was unable to locate the clamps that were "normally in the drawer." At 11:35 AM, E9 returned from central supply with a pair of metal clamps. 2/15/19 (around 4:00 PM) - Interview with E2 (DON) to discuss emergent care in the event R1's dialysis catheter became dislodged or broke and that the policy and information from the dialysis center in R1's dialysis binder did not include anything about the dialysis catheter. E2 said R1's dialysis center told her if the catheter was damaged with bleeding, staff should apply pressure and call 911. E2 provided the surveyor with a paper received today (fax timed at 12:01 PM) from R1's dialysis center on care of a dialysis catheter. Review of the instruction sheet included taping a catheter that was coming out but did not include emergent care in the event of catheter breakage with bleeding. Cross Refer F644. 2. Review of R24's clinical record revealed: 12/11/18 - Admission to the facility with a history of bipolar disorder, depression and a recent suicide attempt. Care plan included:	F 656	engaged on each separate lumen. Fistula graft will be accessed, and ASH catheter scheduled for removal from chest wall. Plan of care for R1 will be to return to his neighborhood within the community. B2. Residents receiving Hemodialysis via ASH catheter are at risk for not having a comprehensive care plan developed for extensive care of the catheter. C3. RCA of deficient practice is related to knowledge of staff developing comprehensive care plans with the potential for an emergent situation beyond the recommendations of the Dialysis Clinic. Licensed Staff will be educated concerning the emergent care and proper procedure for ASH catheter care. MDS coordinator will be educated concerning the importance of documenting care that is being given or assessments being conducted by staff related to any resident with an ASH catheter, in a comprehensive care plan. System changes will involve staff competency checks prior to care of the resident by Staff Educator and requesting written care for residents concerning emergent situations of ASH catheters from the clinic. D4. Monitor residents with ASH catheters daily x 21days for development of comprehensive care plans. Audits will be conducted daily until 100% compliance with communication and written information for plan of care is obtained with dialysis clinic. Then audits will continue weekly x4 then monthly. and reviewed during the quarterly QA meeting.	

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F 656	Continued From page 20 12/13/18 - Care plan for psychotropic medications included an intervention entered 1/28/19 for neuropsychological testing (assessment to determine ability to think and make decisions) on 1/29/19. 1/15/19 - Care plan for verbal aggression related to ineffective coping skills, mental / bipolar disorder and poor impulse control. 1/15/19 - Care plan for physical aggression related to anger, dementia, depression and poor impulse control. The care plan did not include the 11/20/18 PASRR level II determination decision that included specialized services for R24. These findings were reviewed with E1 (NHA), E2 (DON), and E3 (ADON) on 2/29/19 during the exit conference beginning at 4:00 PM.	F 656	A2. R24. Care plan has been updated by SW to include Level 2 PASARR recommendations. Recommendations are being followed and resident is receiving psychiatry and Psych NP visits. B2. Current residents who have received a level 2 PASRR are at risk for not having a comprehensive plan of care developed. C2. RCA of deficient practice is related to the community not having the level 2 PASSAR on admission and once it was obtained it was placed in the medical record versus team discussion and developing a comprehensive plan of care. System changes will involve cross reference F644 D2. Current residents newly admitted with Level 2 PASRR will be monitored x21 days for development of comprehensive care plan. Audits will be conducted r/t the recommendations weekly x4 weeks, then monthly and reviewed during the quarterly QA meeting. DON or Designee 4/12/2019	
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §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 §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.	F 688		4/12/19

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F 688	Continued From page 21 §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: Based on record review, observation and interview it was determined that the facility failed to implement the restorative ambulation program for one (R46) out of 18 residents with investigative areas. Findings include: Review of R46's clinical record revealed: 11/28/18 - Admission to facility for rehabilitation after a recent stroke and left sided weakness. 11/30/18 - A care plan for limited physical mobility included the goal (added 1/10/19) to increase level of ability by ambulating (walking) 200 feet twice a day with a front wheeled walker, gait belt and assist of 1 staff person. Intervention (added 1/22/19) to encourage R46 to ambulate with assistance by staff using rolling walker. 12/4/18 - The admission MDS assessment documented that R46 did not walk in room or hallway. 1/10/19 - CNA documentation included ambulating 200 feet with front wheeled walker twice a day. 1/29/19 - A 60 day Medicare MDS assessment included R46 used a wheeled rolling walker and needed limited assistance when walking in room and extensive assistance while walking in the hallway.	F 688	F 688 SS D Disclaimer Statement Preparation and/or Correction does not constitute admission or agreement of the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of correction of prepared and/or executed solely because it is required by the provisions of federal and state law. This plan represents the facility□s credible allegation of compliance as of 4/12/2019 F 688 SS D F688- Increase/Prevent Decrease in ROM/Mobility A. R46 continues to receive restorative ambulation through the Restorative Nursing Program. Resident ambulates per his preference and is steadily increasing with participation. R46 goals and progress are being monitored weekly by physical therapy. B. Current residents participating in the RNP have the potential to be affected with inaccuracies in documentation. C. RCA is related to available options to choose from within the electronic documentation system when documenting restorative outcomes. Not applicable is one of the choices. C NA□s are not	

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F 688	Continued From page 22 2/12/19 (2:57 PM) - During an interview with the resident, R46 informed the surveyor that s/he wanted to walk "a longer distance" than what the aides have been doing in order to regain use of the weak left leg. R46 pointed out, and the surveyor observed, the handwritten note on the dry erase board in R46's room for the CNA to walk to and from dining room at lunch and dinner. R46 added that s/he would rather "walk down the long hallway and back." 2/13/19 (2:57 PM) - An observation of R46 walking using a front wheeled walker with Physical Therapy in the hallway outside of the rehabilitation department and heading toward the nursing unit. 2/13/19 (3:29 PM) - An interview with E22 (Physical Therapy Aide) confirmed R46 was on a restorative program to walk 200 feet twice a day. January, 2019 - February 2019 - Review of CNA documentation for ambulation found 16 out of 58 (27.5%) ambulation opportunities were recorded as not applicable and not done: - Day shift: not applicable 13 times; refused 1 time; blank 1 time, walked 14 times. - Evening shift: not applicable 3 times; refused 15 times, walked 11 times. 2/15/19 (10:25 AM) - An interview with E14 (CNA) and E23 (CNA currently assigned to R46) to discuss R46's restorative ambulation program. E23 was not sure and would have to look it up in the computer. E14 stated s/he would walk R46 down the long hallway to the other nursing station, rest, and return here. E14 added R46 "really enjoys walking." E14 denied that R46 had ever refused to ambulate for E14. When asked how distance is measured, E14 stated the "dots	F 688	understanding the difference between refuse and N/A. When discussed to have N/A removed this was not an option within the system. Education will be provided with staff concerning definition and appropriate choice for documentation. Education will also include the importance of approaching the resident later in the event of a refusal, and notification of charge nurse. D. Audits will be conducted weekly on the ambulation program documentation x4 weeks until 100% compliance is reached, and then monthly. Results will be discussed at the QA meeting. DON or Designee 4/12/2019	

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F 688	Continued From page 23 on the ceiling are every 5 feet." When asked how often did R46 refuse to walk, E14 said the resident had never refused for E14. This finding was reviewed with E1 (NHA), E2 (DON), and E3 (ADON) on 2/19/19 during the exit conference beginning at 4:00 PM.	F 688		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to ensure consistent communication with the dialysis center for one (R1) out of one resident sampled for dialysis. Findings include: Cross Refer 656, Example 1. October, 2005 - Facility policy entitled Dialysis Communication included the following procedure: - "Before transferring a resident to a dialysis unit, the professional nurse will complete Section One of the Dialysis Communication form." - "The professional nurse will ensure the Dialysis Communication form, along with instruction for the dialysis nurse to complete, is sent with the resident upon transfer to the dialysis unit." - "The dialysis nurse will complete Section Two of the Dialysis Communication form." Review of R1's clinical record revealed:	F 698	F 698 SS D Disclaimer Statement Preparation and/or Correction does not constitute admission or agreement of the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of correction of prepared and/or executed solely because it is required by the provisions of federal and state law. This plan represents the facility□s credible allegation of compliance as of 4/12/2019 F 698 SS D F698- Dialysis A. R1 continues to receive dialysis Monday, Wednesday and Friday without incident. Dialysis staff are always available via telephone and communicates with community for upcoming procedures/changes in plan of care. Communication binder has been	4/12/19

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F 698	Continued From page 24 1/25/19 - Admission to facility with a temporary dialysis catheter in the chest until the dialysis shunt in R1's arm had healed after an infection and recent surgery. 1/27/19 - A care plan for dialysis included the interventions: Do not draw blood or take by blood pressure in my arm with the graft [dialysis shunt]; Do not touch the dialysis catheter; Encourage me to go to my scheduled dialysis appointments on Monday, Wednesday and Friday. January, 2019 - February, 2019 - Review of R1's dialysis communication book which accompanied the resident to and from the dialysis center found the Dialysis Communication forms were in reverse date order with the latest on top. - Facility section of the form was blank: January 2 - Facility section unsigned and medications administered were not written: January 7 and 28; February 1. - Dialysis section incomplete (missing weight, blood pressure and/or signature): January 9, 11 and 28; February 6 and 15. - Dialysis section blank: February 1 and 8. - Back of the binder contained the Dialysis policy dated 6/2010 instead of the revised copy from 12/2018. Reference material from the dialysis center failed to include care of the dialysis catheter. 2/15/19 (8:43 AM) - An interview with E5 (RN, UM) to determine the process for when the dialysis center does not fill out their part of the communication form. E5 said, " We call them." When asked if that was documented in the record, E5 responded "only if there is anything abnormal."	F 698	updated. DON (E2) and clinic administrator have communicated via telephone related to compliance documentation from the dialysis unit. The communication binder is accompanying the resident with each session. The binder order will remain with most recent communication on the top. B. Current residents who receive dialysis have the potential to be affected by incomplete documentation in the communication binder. Nursing supervisor will monitor communication binder. C. RCA of incomplete communication form stem from noncompliance with paper documentation. Education will be provided to Licensed staff nurses concerning the importance of complete documentation and this is monitored on dialysis days by the nursing supervisor. DON and Clinic administrator have discussed RCA on the clinic side. This seems to occur do to extensive documentation in the medical chart and redundancy with paper compliance to document the same. System change will occur when resident leaves session. Finalized notes will be printed and placed in the communication book with the standard form. This will also be monitored at the time resident returns by nursing staff assuming care of resident. D. Audits will be conducted three times weekly x4 until 100% compliant. Then audits will continue monthly and reported to QA committee. DON or Designee 4/12/2019	

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F 698	Continued From page 25 2/15/19 (around 9:00 AM) - An observation of E9 (LPN) explaining to a nurse orienting to the unit how to complete the Dialysis Communication form going line by line. E9 reinforced "on this line you write down all the medication you gave" . . "and sign here." 2/15/19 (around 4:00 PM) - An interview with E2 (DON) to discuss inconsistent completion of the Dialysis Communication forms in R1's dialysis communication book, the incorrect policy dialysis policy and no reference about care of the dialysis catheter, including emergent care if dislodgement or breakage. E2 provided a copy of dialysis catheter care instructions received from the dialysis center earlier today and stated R1's communication binder would be updated. These findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) on 2/19/19 during the exit conference beginning at 4:00 PM.	F 698		
F 730 SS=D	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on interview and review of other facility documentation as indicated, it was determined, that the facility failed to ensure performance evaluations were completed at least every 12 months for two (E20 and E21) out of seven sampled CNAs. Findings include:	F 730	F 730 SS D Disclaimer Statement Preparation and/or Correction does not constitute admission or agreement of the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of correction of prepared and/or	4/12/19

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F 730	Continued From page 26 The facility policy titled, "Non-Exempt Performance Evaluation" (issued May 2011) stated that the performance evaluation will be completed on the employee's anniversary date, or more frequently if the supervisor feels it is necessary. The latest performance evaluation for seven randomly selected CNAs were requested and reviewed. The following was revealed: - E20 (CNA) was hired on 2/3/16, but the latest performance review was not dated or signed by the employee or DON (who wrote the evaluation). - E21 (CNA) was hired on 8/21/16, but the latest performance review was not dated or signed by the DON (who wrote the evaluation). The surveyor was unable to determine when, and if, the performance evaluations were reviewed with E20 (CNA) and E21 (CNA). 2/19/19 at 1:00 PM - An interview with E2 (DON) confirmed the above findings. This finding was reviewed with E1 (NHA), E2 (DON) and E3 (ADON) on 2/19/19 during the exit conference beginning at 4:00 PM.	F 730	executed solely because it is required by the provisions of federal and state law. This plan represents the facility□s credible allegation of compliance as of 4/12/2019 F730 SS D #1 A. E20 did receive an annual performance evaluation that was completed by the DON and reviewed individually with the employee. E20 submitted a written statement to the survey team that her evaluation was completed with the DON. B. Every employee receives an annual evaluation and is scheduled according to their hire date. C. RCA of missing signatures is related to an electronic system and a newly employed DON that was developing processes. The idea is for the manager to complete the evaluation in an electronic system, schedule a meeting with the employee and review the evaluation. The mistake occurred/lesson learned when the employee was instructed to go to their portal and add comments to their evaluation. After this was completed they were instructed to hit another button in the application to send the evaluation back to the manager and this will create an electronic signature. Once the evaluation is sent back to the manager, the manager can read any comments and discuss with employee if needed. Then the manager signs off the evaluation and this creates another electronic signature. The problem occurred when the employee failed to process their evaluation. Multiple phone calls, emails, and text messages were	

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F 730	Continued From page 27	F 730	sent to the employee with no response. E20 is a prn employee and has another full-time job. System changes have been applied to create a more streamline process. The employee will now sign a paper copy with the manager that will be kept in their file, and the manager now uses a laptop computer, helps the employee sign on to the application and has the employee complete the entire process before leaving the evaluation review. D. Random Audits will be conducted by NHA of annual CNA evaluations monthly for 3 months until 100% compliant and then quarterly to maintain compliance. Results will be reported and discussed at the QA meetings. #2 A. E21 received an annual evaluation that was completed by the DON and reviewed individually with the employee. E21 signed her evaluation on paper. B. Every employee receives an annual evaluation and is scheduled according to their hire date. C. RCA of missing signatures is related to an electronic system and a newly employed DON that was developing processes. The idea is for the manager to complete the evaluation in an electronic system, schedule a meeting with the employee and review the evaluation. The mistake occurred/lesson learned when the employee was instructed to go to their portal and add comments to their evaluation. After this was completed they were instructed to hit another button in the	

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F 730	Continued From page 28	F 730	application to send the evaluation back to the manager and this will create an electronic signature. Once the evaluation is sent back to the manager, the manager can read any comments and discuss with employee if needed. Then the manager signs off the evaluation and this creates another electronic signature. The problem occurred when the employee failed to process their evaluation and asked for it to be sent to her email, so she could sign it and scan it back. E21 is a special part time employee that is in school full time. System changes have been applied to create a more streamline process. The employee will now sign a paper copy with the manager that will be kept in their file, and the manager now uses a laptop computer, helps the employee sign on to the application and has the employee complete the entire process before leaving the evaluation review. D. Random Audits will be conducted by NHA of annual C NA evaluations monthly for 3 months until 100% compliant and then quarterly to maintain compliance. Results will be reported and discussed at the QA meetings DON or Designee 4/12/2019	
F 732 SS=E	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked	F 732		4/12/19

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F 732	Continued From page 29 by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility failed to make required staffing information readily available in a readable format to residents and visitors. Findings include: Observations on the following days revealed that the staffing information that included the total number and the actual hours worked per shift by	F 732	F 732 SS E Disclaimer Statement Preparation and/or Correction does not constitute admission or agreement of the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of correction of prepared and/or executed solely because it is required by the provisions of federal and state law.	

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F 732	Continued From page 30 registered nurses and licensed practical nurses was posted so high that it was not readable from wheelchair height: -2/15/19 at 12:40 PM. -2/18/19 at 10:00 AM. -2/19/19 at 10:00 AM. 2/19/19 at 1:00 PM - An interview with E2 (DON) confirmed that the required staffing information that was posted so high that it was not readable from wheelchair height. This finding was reviewed with E1 (NHA), E2 (DON) and E3 (ADON) on 2/19/19 during the exit conference beginning at 4:00 PM.	F 732	This plan represents the facility□s credible allegation of compliance as of 4/12/2019 F 732 SS E F732 □ Nursing Staffing Information. A. There was no one affected by the placement of the staffing schedules. All the staffing sheets were moved to a lower location so anyone in a wheel chair could see all the documents. B. Any resident that resides at Willowbrooke Court has the potential to be affected by the sheets not being at the proper hight. C. The RCA of this is staff education. The staffing coordinator, DON, ADON, Nursing Managers, Nursing Supervisors and the NHA will be educated and given the regulation on the issue and the height requirements. The procedure has been adjusted to have the sheets placed in the lower position so everyone can see them. D. The placement of the staffing sheets will be audited by the DON/NHA or designee 3x per week for two weeks to ensure 100% compliance. Then will be audited 1x per week for two weeks to ensure 100% compliance is maintained. Then the audit will be done 1x per month for three months to ensure 100% compliance is maintained. All audits will be brought to QA for review. DON/Designee April 12 2019	
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6)	F 757		4/12/19

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F 757	Continued From page 31 §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to assess for abnormal movement side effects for one (R24) out of three residents reviewed for medication review and receiving an antipsychotic. Findings include: November, 2014 - Facility policy entitled Abnormal Involuntary Movement Scale (AIMS Test) included if a resident was admitted to the facility already receiving an antipsychotic medication, "the AIMS test will then be administered upon admission or shortly thereafter." Review of R24's clinical record revealed:	F 757	F 757 SS D Disclaimer Statement Preparation and/or Correction does not constitute admission or agreement of the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of correction of prepared and/or executed solely because it is required by the provisions of federal and state law. This plan represents the facility□s credible allegation of compliance as of 4/12/2019 F 757 SS D A.R24 continues to receive antipsychotic medication for appropriate diagnosis is	

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F 757	Continued From page 32 12/11/18 - Admission to facility and already receiving an antipsychotic medication (Seroquel) for bipolar disorder. 12/13/18 - A care plan for psychotropic medications included the intervention to complete the AIMS test every 3 months due to use of antipsychotic medications. 2/18/19 (untimed) - E2 (DON) provided the surveyor with a copy of the AIMS test dated 12/27/19, which was conducted 16 days after admission. R24 had no abnormal movement identified on this assessment. This finding was reviewed with E1 (NHA), E2 (DON), and E3 (ADON) on 2/19/19 during the exit conference beginning at 4:00 PM.	F 757	Bipolar Disorder. Resident has no abnormal involuntary movement as a potential side effect from medication. Medication regime has been evaluated by the Medial Director and Psychiatry with no recommended changes. B. Residents who receive antipsychotic medications have the potential to be affected from a missing AIMS test assessment. C.RCA of missing assessment included multiple omissions in the process. Admission nurse did not open the AIMS assessment due to all residents not requiring this assessment. The assessment was missed in the 24 hour chart check by the 11-7 shift. The community Admission Chart check was not completed in the 24/48 hour window by Nursing Administration. Proper diagnosis was discussed for appropriate usage but again the assessment was not completed. System changes have been put in place to bring all new admission charts to morning meeting on the following business day after admission. Teams of two RNs will review admission charts and follow the process for proper diagnosis and AIMS testing for antipsychotic medications. Any new order for antipsychotic medications of current residents residing in the community will be monitored weekly during clinical meeting by monitoring the PCC dashboard for psychotropic medications ordered in the last 7 days. Education will be provided to Licensed nurses related to the purpose of an AIMS test, and when the assessment is required.	

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F 757	Continued From page 33	F 757	D. Audits will be conducted of all antipsychotic medications and required AIMS testing weekly x4 weeks until 100% compliant and then monthly, this will be reported to QA committee. DON or Designee 4/12/2019	
F 838 SS=F	Facility Assessment CFR(s): 483.70(e)(1)-(3) §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include: §483.70(e)(1) The facility's resident population, including, but not limited to, (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population; (iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population; (iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that	F 838		4/12/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	085009		C 02/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOKE COURT SKILLED CENTER AT MANOR HOUSE	1001 MIDDLEFORD ROAD SEAFORD, DE 19973

(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
F 838	Continued From page 34 may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.70(e)(2) The facility's resources, including but not limited to, (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies; (iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on interview and review of other facility documentation, it was determined that the facility failed to ensure that the Facility Assessment was complete. The facility census was 54. Findings include: Review of the Facility Assessment revealed: -Section 4: The resident population included residents with dementia, behavioral health needs,	F 838	F 838 SS D Disclaimer Statement Preparation and/or Correction does not constitute admission or agreement of the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of correction of prepared and/or executed solely because it is required by the provisions of federal and state law. This plan represents the facility□s	

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F 838	Continued From page 35 incontinence and pain. -Section 5: Staff Competencies: a. Ongoing education via [by name of online education vendor] learning. b. Live education as needed. c. Annual competency check. 2/19/19 at 1:00 PM - An interview with E2 (DON) confirmed that the Facility Assessment lacked the requirement that it must address or include the staff competencies that are necessary to provide the level and types of care needed for the resident population. This finding was reveiwed with E1 (NHA), E2 (DON) and E3 (ADON) on 2/19/19 during the exit conference beginning at 4:00 PM.	F 838	credible allegation of compliance as of 4/12/2019 F 838 SS D A. No resident was affected by this issue. There was no effect to anyone or the environment by this issue. B. There is only one Facility Assessment so there is no potential of affecting anyone or anything in the facility. C. The RCA of this issue is staff knowledge. Nursing competencies and education is done through the computer system Relias. Relias includes education and competencies on Care of Cognitively Impaired, Dementia Care, and Managing Challenging Behaviors. The Assessment mentioned that education was done via Relias but did not specifically mention what education and competencies Relias covers. The Assessment will be changed to specifically mention these competencies as well as other areas of the acuity the facility covers. D. The Assessment will be audited whenever a more complex resident comes into the facility. This will be audited 3x per week until 100% compliance is reached. Then the Assessment will be audited 1x per week to ensure 100% compliance is maintained. Then the Assessment will be audited 1x per month to ensure 100% compliance is maintained. All audits will be brought to QA for review. NHA or Designee 4/12/2019	
F 880	Infection Prevention & Control	F 880		4/12/19

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F 880 SS=D	Continued From page 36 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; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation,	F 880		

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F 880	Continued From page 37 depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (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 (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §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 and interview, it was determined that the facility: - failed to adequately identify and delineate appropriate isolation precautions for one (R42) out of one sampled resident on transmission-based precautions; - failed to ensure tuberculosis testing was completed upon admission for one (R44) out of six sampled residents for infection control review; and - failed to ensure linens were handled in a sanitary manner. Findings include:	F 880	F 880 SS D Disclaimer Statement Preparation and/or Correction does not constitute admission or agreement of the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of correction of prepared and/or executed solely because it is required by the provisions of federal and state law. This plan represents the facility□s credible allegation of compliance as of 4/12/2019	

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F 880	Continued From page 38 1. Transmission Based Precautions 2007 - CDC Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings stated: "Preventing the emergence and transmission of (MDRO) pathogens requires a comprehensive approach that includes administration involvement and measures (e.g. communication systems).... application of infection control precautions during patient care...." January, 2018 - The facility policy Guidelines for Isolation Precautions (I-04.1IC) stated: "To strive to reduce the risk of the transmission of infectious agents by utilizing guidelines established by the Center for Disease Control (CDC)". The following was reviewed in R42's clinical record: 12/22/18 - Review of an acute care hospital note discovered R42 "received treatment since 11/2018 for recurrent pemphigoid lesion." 12/24/18 - A review of care plans reflect the following: - "I am on oral antibiotic medications [name of two antibiotics] related to MRSA of right thigh wound" (last updated 1/12/19) and - " I have potential for impaired skin integrity related to fragile skin and history of Pemphigus.... 11/11/18 Boil to right lateral knee, 12/22/18 Surgical incision to right thigh after after I&D. (last updated 1/24/19) There was no care plan pertaining to contact precautions. 12/26/18 - Progress note documented R42 had an I&D [Incision and Drainage] procedure with excision of abscessed lesion on the right thigh.	F 880	F 880 SS D #1. A- R42 resides in the community with no open areas and requires no isolation. At the time of survey resident had one wound that was scab covered and draining scant amount of serous drainage. Wound was contained, and physician discussed colonization. Staff and residents are not at risk. All wounds and infections are reviewed weekly during the Standard of Care Meeting with the Medical Director. B - Any resident who has a wound or has a surgical procedure is at risk for developing an infection. If a culture is positive the resident may require isolation precautions based on physician recommendations. C- The RCA of this issue is the need to bring admission charts to morning meeting on the next business day post admission and reviewed by teams of two RN□s for any isolation need and MD order. The continued practice of reviewing wounds and infections weekly during the Standards of Care Meeting with the Medical Director will continue. Education will be provided to licensed staff. The requirement of obtaining a physician order for initiating or discounting isolation. D-Audits will be conducted weekly on all infections to ensure compliance for any isolation need. This will be performed weekly x4 weeks until 100% compliant and then monthly. Results will be reported during the QA meeting. #2. A. R44 resides in the community and	

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F 880	Continued From page 39 Final culture documented Methicillin-Resistant Staphylococcus Aureus (MRSA). 2/12/19 at approximately 8:30 AM - Surveyor observed an isolation bin outside of R42's room with signage on the door directing staff/visitors to see the nurse prior to entering room. 2/12/19 - A review of records indicated R42 tested positive for MRSA and, further, that there is no physician order written for contact precautions. 2/12/19 - Progress note documented "....Continues on antibiotic for MRSA to right leg wound without adverse reactions noted... Contact precautions maintained." 2/15/19 at 7:51 AM - A review of computerized resident orders found no physicians' order for contact precautions. 2/15/19 at approximately 12:40 PM - An interview with E9 (LPN) and E17 (LPN) confirmed that staff is informed of contact precautions when report is called from hospital/referring facility. Facility staff will then ensure that supplies and signage posted prior to resident arrival.... A sign is posted on the door instructing people to see nurse prior to entering room. Aides are informed by nurses of the type of precautions and this information is exchanged during shift report. Housekeeping can be informed by floor staff, but also by department supervisor. Issues, such as precautions, are discussed at the daily morning meeting, which is attended by department supervisors. At no time was there mention of the treating provider being consulted about precautions or of the entry of a provider order for same to delineate the organism or appropriate	F 880	has completed her 2 step TB testing. Resident shows no signs or symptoms of TB and has been living in the community since 7/2018. B. Newly admitted residents to the community are at risk for refusals of the TB testing. C. RCA is related to resident having impaired cognitive status, combative behaviors and multiple refusals of care during the first week after admission to the community during the initial adjustment period. Nurses notes documented a refusal and nurse entered the EMAR as a refusal. Within the next 72 hours when the TB test was scheduled to be read, the nurse documented refusal again and this caused the TB testing to fall off the EMAR. Nurses did not follow common practice of rescheduling the TB testing after a refusal. Resident received her PPD when the second step was scheduled, and this is when it was noted. There was not a prompt for nursing to reschedule the initial TB testing. System changes include Infection Prevention designee to monitor all newly admitted residents for implementation of the TB screening. All Licensed Nurses will be educated pertaining to TB refusals from residents and scheduling. D . Audits will be conducted on each new admission weekly x4 weeks until 100% compliant. The audits will continue monthly with results discussed at QA meetings. #3 A3. No resident was affected by this issue. In-Services were completed with the Laundry Staff on 3/12/19	

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F 880	Continued From page 40 precautions. 2/15/19 at approximately 1:30 PM - An interview with E3 (ADON/infection control nurse) revealed that the facility would contact with case manager in hospital if the resident was coming to facility. Information would then be conveyed through inter-agency report and the daily morning meeting, which is attended by all disciplines. Necessary items, including signage for the door, would be available prior to resident arrival. It is the responsibility of managers to communicate precautions to staff. Staff are also trained as to proper procedure during orientation. Signage is posted on the door to the room to alert family, staff (some are floaters or "as needed" staff) to see the nurse prior to entering room. When questioned as to whether there is information entered into the computer that would convey the type of infection and/or isolation needed, E3 indicated this information is conveyed via report, from managers to staff and with signage on the door to see RN. There was no mention of the treating provider being consulted about precautions or of the entry of a provider order for same to delineate the organism or appropriate precautions. 2/18/19 - Progress note included "....no adverse reactions noted outwardly from antibiotic therapy for MRSA to wound to right outer leg..." 2/18/19 at 9:23 AM - Surveyor observed that the container with isolation supply bin was no longer in front of R42's room, although sign directing staff/visitors to see nurse remained. 2/18/19 at 12:31 PM - An interview with E13 (CNA) and E12 (LPN) confirmed that R42 is now off precautions, which happened "a couple of days ago". The signage on the door removed at	F 880	B3. Any Willowbrooke court resident who receives laundry services from the facility has the potential to have their clean laundry dropped on the floor. C3. The RCA is staff education. Laundry employees have been in-serviced to ensure this does not happen again. All new employees will be educated upon hire. All in-services will cover the policy and procedure of the facility. D3. This will be audited 3x per week until 100% compliance is reached. Then this will be audited 1x per week to maintain compliance. Then this will be audited 1x per month to ensure compliance is maintained. All audits will be brought to QA for review. A4. No resident was affected by this issue. All Dietary staff will have been in-serviced on how to transfer clean linen from one area to another. B4. Dietary employees have the possibility to be affected by this practice. All Dietary employees have been in-serviced on the proper transportation of linen from one area to another. C4. The RCA is staff education. Dietary employees have been in-serviced to ensure this does not happen again. All new employees will be educated upon hire. In-services will cover the policy and procedure of the facility. D4. This will be audited 3x per week until 100% compliance is reached. Then this will be audited 1x per week to maintain compliance. Then this will be audited 1x per month to ensure compliance is maintained. All audits will be brought to QA for review.	

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F 880	Continued From page 41 approximately 12:33 PM. 2/19/19 at approximately 4:00 PM - During exit conference, E2 (DON) conveyed that R42 was not on true contact precautions due to the wound being covered with a bandage. E2 indicated that the isolation supply bin and sign were placed at R42's room as a result of an "overzealous" employee, such that no order was needed. Based on the foregoing circumstances, it was determined that the facility's program for isolation precautions failed to adequately identify and delineate appropriate isolation precautions for the protection of the affected resident and others within the facility. 2. TB Testing February, 2017 - Facility policy entitled Resident and Employee Screening for Tuberculosis included: - "two-step intradermal TST [TB Skin Test under the skin] will be the method used for initial testing." - all newly admitted residents "will be screened using the two step TST." Review of R44's clinical record revealed: 7/13/18 - Admission to facility for long term care. 7/13/19 - Nursing note documented the resident refused the TB skin test. 7/24/18 - First TB skin test completed. 2/18/19 (3:00 PM) - During an interview with E3 (ADON) to review the infection control program, the delay of the resident TB test was reviewed and E3 stated the resident may have refused. Review of R44's eMAR and nursing notes found	F 880	Infection Control/Prevention nurse or designee 4/12/2019	

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F 880	Continued From page 42 no evidence that the TB skin test was re-attempted during the 10 days following the initial refusal on 7/13/19. 3. Linen Handling a. 2/15/19 (9:34 AM) - Observed E11 (Dietary Aide) carry a stack of folded tablecloths held tightly against his/her torso/uniform, contaminating the clean linens. b. 2/18/19 (around 9:43 AM) - Observed E10 (Laundry Aide) dropped a clean piece of freshly washed, wet, personal resident clothing on the floor contaminating the clean item prior to placing in the dryer. 2/18/19 (3:00 PM) - During an interview with E3 (ADON) to review the infection control program, the aforementioned linen contamination was reviewed and E3 offered no explanation. The findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) on 2/19/19 during the exit conference beginning at 4:00 PM.	F 880		

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

DHSS - DHCQ
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(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: Willowbrooke Court Manor House **DATE SURVEY COMPLETED: February 19, 2019**

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTIONOF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced annual and complaint survey was conducted at this facility from February 11, 2019 through February 19, 2019. The facility census the first day of the survey was 54. During this period an Emergency Preparedness Survey was also conducted by the State of Delaware's Division of Health Care Quality Long Term Care Residents Protection in accordance with 42 CFR 483.73. For the Emergency Preparedness survey no deficiencies were cited. Abbreviations/Definitions used in this report are as follows: NHA - Nursing Home Administrator; DON - Director of Nursing; ADON - Assistant Director of Nursing;	Disclaimer Statement Preparation and/or Correction does not constitute admission or agreement of the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of correction of prepared and/or executed solely because it is required by the provisions of federal and state law. This plan represents the facility's credible allegation of compliance as of 4/12/2019	
3201	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.0	**Scope**		
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements.** **This requirement is not met as evidenced by:** Cross Refer to the CMS 2567-L survey completed February 19, 2019: F550, F571, F641, F644, F656, F688, F698, F730, F732, F757, F838, and F880. TITLE 16 Health and Safety - Regulatory Provisions Concerning Public Health		

Provider's Signature [signature] Title Administrator Date 3/20/19

NAME OF FACILITY: Willowbrooke Court Manor House

DATE SURVEY COMPLETED: February 19, 2019

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTIONOF DEFICIENCIES	COMPLETION DATE
	CHAPTER 11. LONG-TERM CARE FACILITIES AND SERVICES Subchapter VII. Minimum Staffing Levels for Residential Health Facilities § 1162 Nursing staffing. (a) ... Every residential health facility shall display, for each shift, the names and titles of the nursing services direct caregivers assigned to each floor, unit or wing and the nursing supervisor on duty. This information shall be conspicuously displayed in common areas of the facility, in no fewer number than the number of nursing stations... Based on observation and interview, it was determined that the facility failed to conspicuously display the names and titles of the nursing staff direct caregivers assigned to each unit and the nursing supervisor on duty for each shift in common areas of one (Rehoboth) of the two nursing wings/units. Findings include: . Observations in common areas of the Rehoboth Wing revealed that the required staffing information was not posted on: -2/15/19 at 12:40 PM. -2/18/19 at 10:00 AM. -2/19/19 at 10:00 AM. 2/19/19 at 1:00 PM - An interview with E2 (DON) confirmed that the required staffing information was not conspicuously display in common areas of the Rehoboth Wing. This finding was reviewed with E1 (NHA), E2 (DON) and E3 (ADON) on 2/19/19 during the exit conference beginning at 4:00 PM.	A. The nursing schedule was posted on the Rehoboth Neighborhood. B. No residents will be at risk. The schedule is posted daily. C. RCA of this deficiency occurred when it was determined that the schedule could be posted in a centralized area with easy access for all family members, staff and residents to see. It was posted in a common area clearly visible. Staffing for Health Center is one schedule-not separated by hallway assignments. If the neighborhoods had separate staffing than individualized schedules would be posted in each area. Education will be provided to DON, Nursing Supervisors, and Nursing Scheduler by Staff Educator. D. Audits will be conducted on a daily bases X14 days until 100%compliance is reached and then will be monitored randomly three times monthly.	Staff Educator 4/12/19

Provider's Signature [signature] Title ADMINISTRATOR Date 3/20/19

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STATE SURVEY REPORT

NAME OF FACILITY: Willowbrooke Court Manor House **DATE SURVEY COMPLETED: February 19, 2019**

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTIONOF DEFICIENCIES	COMPLETION DATE
		Results will be discussed at QA meetings.	

Provider's Signature _____ Title Administrator Date 3/20/19