

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

PRINTED: 06/05/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085053	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/08/2019
NAME OF PROVIDER OR SUPPLIER THE MOORINGS AT LEWES		STREET ADDRESS, CITY, STATE, ZIP CODE 17028 CADBURY CIRCLE LEWES, DE 19958		
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F 000	<p>INITIAL COMMENTS</p> <p>An unannounced complaint survey was conducted at this facility from April 2, 2019 through April 8, 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 37. The survey sample totaled eight (8).</p> <p>Abbreviations and Definitions used in this report are as follows:</p> <p>Allegation - a claim that someone has done something illegal or wrong, typically one made without proof; Alzheimer's Disease - brain disorder causing loss of memory, thinking and language; AM - morning from midnight to noon; BIMS (Brief Interview for Mental Status) - test to measure thinking ability with score ranges from 00 to 15. 13-15: Cognitively intact (able to make own decisions) 8-12: Moderately impaired (decisions poor, cues / supervision required) 0-07: Severe impairment (unable to make own decisions); CIS - computer information systems; CNA - Certified Nurse's Aide; Cognition - mental processes or thinking; Cognitively Impaired - abnormal mental processes/thinking OR mental decline including losing the ability to understand, talk or write; Cognitively Intact - able to make own decisions; Dementia - brain disorder with loss of mental functions such as memory and reasoning that is severe enough to interfere with a person's daily</p>	F 000		

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

TITLE

(X6) DATE

Electronically Signed

04/30/2019

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 functioning; DON - Director of Nursing; e.g. - for example; EMR - electronic medical record; Foley catheter - indwelling urinary catheter to drain urine from bladder; Fracture - a broken bone; Hospice - end of life care; HR - Human Resource Manager; Indwelling (urinary) catheter - generally referred to as a "Foley" catheter which is an indwelling urinary catheter to drain urine from bladder; LPN - Licensed Practical Nurse; MAR - medication administration record; MD - Medical Doctor; MDS (Minimum Data Set) - standardized assessment documentation utilized in nursing homes and reported to Medicare; mg (milligrams) -unit of weight, 1 mg equals 0.0035 ounce; Moderate Cognitive Impairment - decisions poor, cues / supervision required; Neuromuscular dysfunction of bladder - is a dysfunction of the urinary bladder due to disease of the nervous system or peripheral nerves involved in the control of urination; NHA - Nursing Home Administrator; NON - new order noted; Ombudsman - independent person who investigates resident complaints and helps to achieve agreement with the facility; PM - evening from noon to midnight; PRN - as needed; Psychosocial abuse - any action that causes the patient emotional harm or anguish. May cause residents to feel extreme sadness, fear, and anxiety; q - every; Rehabilitation - treatment for recovery from injury or disease;	F 000		

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F 000	Continued From page 2 Retaliation - an act of revenge; RN - Registered Nurse; RNAC - Registered Nurse Assessment Coordinator; Severe Cognitive Impairment - unable to make own decisions; Substantiate - provide evidence to support or prove the truth of; SW - Social Worker; TAR (treatment administration record) - list of daily/weekly/monthly treatments performed; Tibia - bone in the lower leg; Urologist - physician that specializes in disorders of the urinary tract. Vulnerable - in need of care, support, or protection because of age, disability or risk of abuse or neglect.	F 000		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.	F 585		5/31/19

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F 585	Continued From page 3 §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;	F 585		

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F 585	<p>Continued From page 4</p> <p>(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;</p> <p>(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;</p> <p>(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and</p> <p>(vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review, interview and review of other facility documentation it was determined that for two (R3 and R6) out of three sampled residents investigated for concerns/grievances, the facility failed to make prompt efforts to resolve grievances. For R3, the facility failed to identify multiple verbal complaints as grievances. For R6, the facility failed to thoroughly investigate a written grievance and</p>	F 585	<p>A. Resident's R3 and R6 grievances have been resolved. The residents and their responsible parties were contacted and provided with the results of the investigation. The facility at the time of the survey did not follow up in writing per policy. The facility recognizes that all grievances must be investigated with the resident/ responsible party notified of the</p>	

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F 585	<p>Continued From page 5</p> <p>respond to the complainant in writing. In addition, the facility's grievance postings failed to list the name and contact information of the Grievance Officer. Findings include:</p> <p>Review of the facility's policy and procedure (effective 4/1/17) entitled "Grievances/Complaints, Filing" included that:</p> <ul style="list-style-type: none"> -Residents and their representatives have the right to file grievances, either orally or in writing, to the facility staff or to the agency designated to hear grievances. -The administrator and staff will make prompt efforts to resolve grievances to the satisfaction of the resident and/or representative. -Grievances and/or complaints may be submitted orally or in writing, and may be filed anonymously. -The resident, or the person filing the grievance and/or complaint on behalf of the resident will be informed (verbally and in writing) of the findings of the investigation and the actions that will be taken to correct any identified problems. The Administrator, or his /her designee, will make such reports orally within 10 working days of the filing of the grievance or complaint with the facility. A written summary of the investigation will also be provided to the resident, and a copy will be filed in the business office. <p>1. 4/8/19 at 10:00 AM - An observation of the nursing unit with E2 (DON) lacked evidence of any postings in prominent locations identifying who the Grievance Officer was and how to contact them (e.g., name, business address, email and business phone number). At this time E2 was asked how do residents and families know how to file a grievance or complaint. E2 provided a handout that is included in the inpatient handbook given to residents on admission entitled "Grievances - Skilled Care"</p>	F 585	<p>outcomes. A Grievance Official has been identified as the Director of Social Services, and is responsible to oversee the grievance process, as well as receiving and tracking grievances. Grievance postings have been posted at the healthcare center at wheelchair height and at prominent locations throughout the facility, the contact information of the grievance official with whom a grievance can be filed, his or her name, business address (mailing and email) and business phone number.</p> <p>B. All residents have the potential to be affected by the deficient practice.</p> <p>C. The root cause of the deficient practice is that the facility failed to inform, post and implement the grievance process as outlined on the current policy and procedure and as mandated by the state and federal regulations. The Director of Social Services/Designee will send a correspondence to all residents/resident representatives on the current grievance policy, the Grievance Officer's name, address (mailing and email), business phone number, and a reasonable expected time frame for completing the review of the grievance. The correspondence will also include the name and phone number of pertinent state agencies with whom grievances may be filed. The Grievance Officer will also be introduced to the resident council and will discuss the grievance process on May 20, 2019. The Grievance Officer will conduct an in-service training for all employees to review the current Grievance policy. The facility will review its current policy and educate the staff on the</p>	

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F 585	<p>Continued From page 6 (undated) included that: -All staff from time to time may receive a complaint/concern regarding community services. The staff working in the area/department will make every effort to address the complaint concern at the time they become aware of the issue. If the staff member is not able to resolve the complaint to the resident's satisfaction, the staff member will refer the issue to the department manager or the Executive Director. A concern report will be completed if the resident's complaint was not made in writing. All records of complaint will be recorded in a log. But, this handout did not contain who the Grievance Officer was and how to contact them or that complaints can be made anonymously.</p> <p>2. Review of R6's clinical record revealed:</p> <p>3/14/19 - R6 was admitted to the facility for rehabilitation after a right tibia (lower leg bone) fracture (broken bone).</p> <p>3/18/19 - Documentation by E20 (RN) on the Concern Form that F2 (R6's family member and primary contact) filed a complaint that the nursing station was called three times for a nurse to put R6 back to bed and waited over an hour three times. E10 (CNA) said R6 refused to get washed up which F2 said was not true. Also, F2 stated that E10 did not change R6 after E10 said that he/she did change R6.</p> <p>3/19/19 at 10:00 AM - Documentation by E7 (SW) on the Concern Form revealed that per follow up with E20 (RN), F2 made the complaint over the weekend to E9 (RN, Supervisor).</p> <p>3/19/19 (not timed) - Documentation by E2 (DON) on the Concern Form revealed that she spoke to</p>	F 585	<p>reporting guidelines and executing resolution to all grievances reported, training will be completed by May 13, 2019. The Grievance Officer will complete a spreadsheet for tracking investigations that will be reviewed weekly by the Executive Director/Administrator. D. A weekly audit will be conducted by the Grievance officer to follow up on any grievances that require resolution. The Grievance Officer will conduct weekly grievance audits for 12 weeks to ensure that the outcomes are communicated to the responsible party/resident. Once 100% compliance has been achieved, the Grievance Officer will conduct monthly audits and will report their total monthly grievances to the QAPI committee. Attachment = Grievance Policy, Grievance Log Audit</p>	

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F 585	<p>Continued From page 7</p> <p>E9 (RN, Supervisor) who stated R6 was taken care of appropriately and R6 did not want a bath. E2 wrote that she spoke with R6 who "had no complaints, stated the staff were nice and (he/she) doesn't like showers."</p> <p>4/4/19 at 4:30 PM - During an interview, E2 (DON) confirmed that the facility did not interview E10 (the CNA named in the complaint) or F2 (the family member who made the complaint). E2 stated she spoke with R6, but did not respond to the complainant (F2) either verbally or in writing.</p> <p>3. Cross refer F690.</p> <p>Review of R3's clinical record revealed:</p> <p>5/28/18 - R3 was admitted to the facility.</p> <p>10/26/18 - 4/3/19 - Review of the facility's "Compliment/Concern Incident Log" since 10/26/18 revealed no concerns documented from/about R3.</p> <p>11/15/18 at 7:55 AM - An email from E18 (Facility Ombudsman) to E7 (SW) was provided by facility in regards to another resident grievance, but included that R3 has had concerns because staff are not answering call bells.</p> <p>2/26/19 - A quarterly MDS revealed R3 had a BIMS of 15 (cognitively intact) and a urinary catheter.</p> <p>1/24/19 - A physician order to change Foley catheter every 30 days per Urologist.</p> <p>4/4/19 at 8:30 AM - During a medication administration observation of E8 (LPN), R3 stated concerns that for the past five days he/she has</p>	F 585		

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F 585	<p>Continued From page 8</p> <p>been asking the nurses to check the computer because his/her catheter is over due to be changed, meals are late, the service is terrible and there are long waits for his/her call bell to be answered. There was no Concern Form initiated by E8 after R3 verbalized these concerns.</p> <p>4/4/19 at 4:30 PM - During an interview, E9 (Charge RN) verified that R3's foley catheter was last changed 34 days ago and that the way the order was entered into the EMR (electronic medical record) did not trigger to the TAR (treatment administration record) to remind the nurses to change it every 30 days. E9 stated she corrected the order and will change R3's Foley catheter today.</p> <p>4/5/19 at 8:45 AM - During an interview with R3, it was confirmed that the Foley catheter was changed last evening and that R3 had complained to E1 (NHA) four or five days ago about the poor service, long waits for call bells to be answered and late meals. R3 said he/she has complained to E1 multiple times about these issues since admitted to the facility. After each complaint the problems seem to improve for a short time, but then return and he/she had to complain again. R3 stated complaints were made about these issues to multiple nurses and CNA's many times, but did not want to provide their names.</p> <p>4/5/19 at 12:40 PM - During an interview, E7 (SW) confirmed there were no Concern Forms available for the above stated concerns made to E1 (NHA).</p> <p>These findings were reviewed with E2 (DON), E3 (RNAC), E7 (SW), E15 (RN Supervisor), E5 (Corporate Clinical Consultant) and E4 (Clinical</p>	F 585		

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F 585 F 600 SS=G	Continued From page 9 Analysis - CIS) on 4/8/19 during the exit conference beginning at 10:35 AM. Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interview, review of resident's clinical record and other facility documentation, it was determined that for one (R8) out of three sampled residents reviewed for abuse, the facility failed to ensure that R8 was free from abuse. This resulted in psychosocial harm which was inflicted when E11(CNA) flicked R8's nipples in retaliation for being pinched by R8. As a result, R8 exhibited signs of being fearful when care was provided. Findings include: Cross refer F607, F608 and F609 #1. The facility policy and procedure (last revised 10/23/18) entitled "Abuse (Resident Abuse)" included: a. Each new employee shall be oriented to the	F 585 F 600	A. Individual/Resident Impacted • Resident (R8) was found to have been affected by this deficient practice. B. Identification of other residents with the potential to be affected • All residents are at risk to be potentially affected by the deficient practices. C. System Changes • The root cause of the event is that the employee while aware of the regulations and company policy failed to report abuse immediately after it occurred. • The facility will report abuse allegations to the police department as mandated by law.	4/18/19

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F 600	<p>Continued From page 10</p> <p>facility's policies and procedures regarding the prevention, reporting, and investigation process associated with resident abuse.</p> <p>b. The Administrator/DON/Wellness Nurse or designee will assure adequate supervision of staff to identify inappropriate behaviors such as using derogatory language, rough handling, ignoring residents while giving care, and directing residents who need toileting assistance.</p> <p>6/9/16 - R8 was admitted to the facility with Alzheimer's dementia.</p> <p>12/14/18 - A quarterly MDS documented a BIMS score of 6 out of 15, which reflected that R8 had severe cognitive impairment.</p> <p>1/6/19 - At approximately 2:30-2:45 PM (as documented in E12's, CNA written statement), E12 and E13 (CNA) witnessed E11 (CNA) touch R8 inappropriately.</p> <p>1/6/19 - A written statement from E12 (CNA) included: "On 1/6/19 I assisted (E11, CNA) with dressing and changing a resident (R8). As we were sitting (R8) up I noticed (R8) grabbing for something to hold onto. (R8) reached for (E11's) jacket. As (R8) did (reach for E11's jacket), (E11) started to pluck (R8) on (his/her) nipples. I asked (E11) what was (he/she) doing and (E11) stated that (R8) was pinching me. I told (E11) (R8) wasn't, that (R8) was just looking for something to hold onto. (E13, CNA) was at the foot of the bed and witnessed it all."</p> <p>A written statement (undated) from E13 (CNA) included: "On January 6, 2019 (E12, CNA), (E11, CNA) and I went into (R8's) room to get (R8) dressed and up for the afternoon. (E12) was</p>	F 600	<ul style="list-style-type: none"> • The facility will follow the guidelines for events that require reporting to the DLTCRP as specified. • The DON conducted an in-service training on the abuse policy and procedure for all staff and completed on 4/5/2019. Annual Abuse in-service training will be conducted by the Social Worker/Designee and as needed for employees that are involved in any alleged abuse occurrence. • The policy titled Abuse (Resident Abuse) is revised • The Compliance Officer conducted compliance training on 4/17/2019 and 4/18/2019. • All new hires will be educated on the Abuse Policy and Procedure during orientation. • The Administrator/Designee will conduct an audit of all reportable events prior to submission to DLTCRP. • The CNA (E11) was terminated as a result of the substantiated abuse that was reported. <p>D. Success Evaluation</p> <ul style="list-style-type: none"> • Provide education to the employees on the policy and procedure regarding the prevention, reporting and investigation process associated with resident abuse, quarterly during their staff meetings. • Trainings on abuse will be conducted quarterly and annually by the HR manager or designee. • Quarterly audit reviews of staff education related to prevention, reporting and investigation process associated with resident abuse will be conducted by HR Manager or designee x 4 quarters. If 	

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F 600	<p>Continued From page 11</p> <p>getting (R8's) clothes out, and I was at the end of the bed when we both heard (R8) yell. I looked up and (E11) had flicked (R8's) nipples more than once. (E12) yelled, 'Are you crazy?' (E11) said, (R8's) pinching me so I'm getting (him/her) back. (E12) stated, (R8's) just looking for something to hold onto. (R8) then started to cry. Later that evening I was doing rounds and (R8) asked to see my face before I touched (him/her). I feel (R8's) frightened now."</p> <p>1/7/19 (approximately 2:30 PM) - Documentation in the facility reported incident report revealed that E2 (DON) and E3 (RNAC) became aware of the alleged abuse reported by E12 (CNA).</p> <p>1/7/19 (4:57 PM) - The allegation of abuse for R8 was reported to the State Agency. The facility incident report for the State Agency included: "A staff member reported to RNAC and DON that (he/she) witnessed an abusive act committed against a resident. The act occurred on January 6, 2019. The staff person alleges that (he/she) and two other staff members were providing care for (R8) and one of the other staff members touched (R8) inappropriately. (R8) is alert and oriented to self only, and unable to validate the occurrence."</p> <p>1/8/19 - A written statement from E11 (CNA) included: "On Sunday the 6th I was with (R8's) aide. (R8) stayed in the bed majority of the day (related to) (R8) not wanting to get up. Close to 3:00 (PM) myself and two other aides went in and asked (R8) if (he/she) was ready to get up. (R8) said yes so we proceeded to get (R8) dressed. While turning (R8) toward me to pull (his/her) pants up, (R8) pinched me under my arm/breast. So I said in a joking matter, 'Owww (R8) that hurts!' And as I turned (R8) back over said I</p>	F 600	<p>100% compliance is achieved, audits will be completed annually by HR Manager.</p> <ul style="list-style-type: none"> • DON/Designee will review all events, which will be reported at the monthly QAPI committee meeting. • All reportable events are reported quarterly to the Professional Services Committee. 	

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F 600	<p>Continued From page 12</p> <p>should give you a "tittie/boob twister" for that and we all laughed. We finished pulling (R8's) pants up, put on (R8's) jacket and put (R8) in (his/her) chair. I pushed (R8) out to the television area. Shortly after that (R8's) daughter came and pushed (R8) back to (R8's) room, rang (the call bell) and said that (R8) wanted to go back to bed. I informed her (the daughter) that I just got (R8) up for the day, so (the daughter) talked (R8) into staying up for dinner. Also, (R8's) favorite football team was about to play, so we assured (R8) that if (he/she) ate in the dining room, we would turn it on. Then I left. Not even 5-10 minutes later (R8's) bell rang again and I answered it. (R8's) daughter said (R8) doesn't want to wait so I said okay. I asked the daughter if she wanted me to put (R8's) night clothes on and (R8) said no. Another aide came in to accompany me if needed (them to assist me with (R8's) care). After (R8) was settled in bed, myself, (R8's) daughter and another aide talked for a few minutes. I also had (R8) on the 3-11 shift, so I undressed (R8), changed (R8) and put (R8's) gown on for bed. While doing this (R8) was yelling, stiffening up, crossing her legs, but I completed the task as usual. I noticed no bruises or anything on (R8), other than the patch on (his/her) butt." E11's statement included that (he/she) was pinched by (R8), although E11's documentation at 3:45 PM on January 6, 2019 lacked evidence of any behaviors.</p> <p>1/10/19 - The facility did not report the allegation to the police until after the State Agency investigator was in the building.</p> <p>1/18/19 - Research revealed that per the Attorney General Office, Delaware State Police (DSP) will be charging E11 (CNA) with "Unlawful Sexual Contact and Abusing a Vulnerable Adult."</p>	F 600			

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F 600	Continued From page 13 2/10/19 - A service letter created by E21 (HR) for E11(CNA) at the time of termination included: "The employee was counseled, warned, reprimanded, suspended or discharged as a result of reasonably substantiated incidents involving abuse of patients." 3/12/19 - An annual MDS revealed a BIMS score of 2 out of 15, which reflected that R8 was severely cognitively impaired. 4/5/19 (9:55 AM) - In an interview with E2 (DON), E2 reported that the reason why E12 (CNA) did not report what he/she had witnessed the same day as it occurred, was related to E12 had reported E11 (CNA) for other things at another facility. E2 stated that E12 reported that nothing was done about it (and the witnessed act really bothered E12), so E12 thought that he/she needed to report it the next day. E2 stated that E11 was terminated. E2 reported that the facility could not substantiate abuse of the resident but having two witnesses was enough for E2 to terminate E11. The facility failed to ensure that R8 was free from abuse related to E11 (CNA) flicking R8's nipples during care, which resulted in causing R8 to be apprehensive and fearful during care. Although R8 was cognitively impaired, E11's actions would result in psychosocial harm for any reasonable individual. These findings were reviewed with E2 (DON), E3 (RNAC), E7 (SW), E15 (RN Supervisor), E5 (Corporate Clinical Consultant) and E4 (Clinical Analysis - CIS) on 4/8/19 during the exit conference beginning at 10:35 AM.	F 600			
F 607	Develop/Implement Abuse/Neglect Policies	F 607			5/13/19

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F 607 SS=E	Continued From page 14 CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Cross refer F600 and F609. Based on interview and review of the facility's policies and procedures, it was determined that the facility failed to develop written policies and procedures, which included the reporting requirement for allegations of abuse. Findings include: Review of the facility's policy and procedure (last revised 10/23/18), entitled "Abuse (Resident Abuse)", revealed that the policy failed to include immediate reporting within two (2) hours to the State Agency for an allegation of abuse. These findings were reviewed with E2 (DON), E3 (RNAC), E7 (SW), E15 (RN Supervisor), E5 (Corporate Clinical Consultant) and E4 (Clinical Analysis - CIS) on 4/8/19 during the exit conference beginning at 10:35 AM.	F 607	A. The Springpoint policy and procedure specifies the reporting guidelines for the state as specified under Title 16 for Long Term Care Facilities and Services. B. All residents have the potential to be affected by the deficient practice. C. The root cause of the deficient practice is failure of the staff to immediately report the abuse as specified on the Delaware reporting guidelines for abuse. The facility reviewed and revised the abuse policy to reflect the reporting guidelines for the state. All policy reviews and revisions will be implemented immediately; trainings on the policies will be conducted no later than May 13, 2019. D. The abuse policies have been updated as required by state and federal regulations.		
F 608 SS=E	Reporting of Reasonable Suspicion of a Crime CFR(s): 483.12(b)(5)(i)-(iii) §483.12(b) The facility must develop and	F 608		5/13/19	

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F 608	Continued From page 15 implement written policies and procedures that: §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. (i) Annually notifying covered individuals, as defined at section 1150B(a)(3) of the Act, of that individual's obligation to comply with the following reporting requirements. (A) Each covered individual shall report to the State Agency and one or more law enforcement entities for the political subdivision in which the facility is located any reasonable suspicion of a crime against any individual who is a resident of, or is receiving care from, the facility. (B) Each covered individual shall report immediately, but not later than 2 hours after forming the suspicion, if the events that cause the suspicion result in serious bodily injury, or not later than 24 hours if the events that cause the suspicion do not result in serious bodily injury. (ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. (iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on interview and review of the facility's policy and procedure, it was determined that the facility failed to develop and implement written policies and procedures that included requirements for "covered individuals" (employees) that ensured reporting of suspicion of a crime occurring in a federally-funded long-term care facility in accordance with section 1150B of the Social Security Act. Findings include:	F 608	A. The Springpoint policy and procedure specifies the reporting guidelines of reasonable suspicion of crime for the state as specified in accordance to 1150B of the Social Security Act. B. All residents have the potential to be affected by the deficient practice. C. The root cause of the deficient practice is failure of the staff to immediately report the abuse as specified		

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F 608	Continued From page 16 Cross refer F600 and F609. Review of the facility's policy and procedure (last revised 10/23/18), entitled "Abuse (Resident Abuse)", lacked evidence of reporting requirements for suspicion of a crime. 4/5/19 at approximately 3:00 PM - An interview with E6 (RN, Corporate Director of Health Services), confirmed that the current policy failed to include reporting requirements for suspicion of a crime. These findings were reviewed with E2 (DON), E3 (RNAC), E7 (SW), E15 (RN Supervisor), E5 (Corporate Clinical Consultant) and E4 (Clinical Analysis - CIS) on 4/8/19 during the exit conference beginning at 10:35 AM.	F 608	on the reporting guidelines on reporting of reasonable suspicion of a crime in accordance with 1150B of the Social Security Act Delaware reporting guidelines for abuse. The facility reviewed and revised the abuse policy to reflect the reporting guidelines as specified on 1150B of the Social Security Act. All policy reviews and revisions will be implemented immediately; trainings on the policies will be conducted no later than May 13, 2019. D. The abuse policies specific to the guidelines for reporting of reasonable suspicion of a crime have been updated as required by state and federal regulations.	
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in	F 609		4/30/19

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F 609	<p>Continued From page 17</p> <p>accordance with State law through established procedures.</p> <p>§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview, record review and review of State of Delaware Division of Healthcare Quality (DHCQ) Incident Referral system and other facility documentation, it was determined that the facility failed to identify allegations of abuse, which resulted in the failure to immediately report allegations of abuse for two (R2 and R8) out of three sampled residents reviewed for abuse. Findings include:</p> <p>Cross refer F607 and F608.</p> <p>Review of the facility policies and procedures (last revised 10/23/18) entitled "Abuse (Resident Abuse)" included:</p> <p>a. Each new employee shall be oriented to facilitie's policies and procedures regarding the prevention, reporting, and investigation process associated with resident abuse.</p> <p>b. Any staff member who suspects that a resident is being abused should report any suspicion of abuse to a nursing supervisor.</p> <p>c. The nursing supervisor on duty shall immediately report any alleged violations of this prevention policy to the Administrator or</p>	F 609	<p>A. Individual/Resident Impacted The corrective action taken for the resident (R2 and R8) found to have been affected by the deficient practice. Hospice C.N.A. was removed from premises at knowledge of event. Housekeeper that heard the incident was counseled immediately in the event of future incidents. C.N.A. for R8 was terminated immediately at knowledge of the event. C.N.A. that reported the event was counseled immediately in the event of future incidents. The DON/Designee is responsible to ensure the timeliness of reportable events to be reported to the DLTCRP following the current guidelines.</p> <p>B. Identification of other residents with the potential to be affected All residents are at risk to be potentially affected by the deficient practices.</p> <p>C. System Changes The root cause is the employee/s who witnessed the incidents failed to comply with the state reporting guidelines despite previous education of policy and guidelines. Conduct in-service training by 5/6/19 for</p>	

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F 609	<p>Continued From page 18 designee.</p> <p>d. Each new employee will be informed of his or her responsibility to immediately report any violations or alleged violations. Failure to do so will result in disciplinary action.</p> <p>e. The Administrator will contact the Office of the Ombudsman, the State Department of Health and all other appropriate agencies will be notified as mandated for the State immediately and follow up with written notification within 72 hours.</p> <p>1. Cross refer to F600.</p> <p>6/9/16 - R8 was admitted to the facility with Alzheimer's dementia.</p> <p>12/14/18 - A quarterly MDS documented a BIMS score of 6 out of 15, which reflected R8 was severely cognitively impaired.</p> <p>1/6/19 - At approximately 2:30-2:45 PM [as documented in E12's (CNA) written statement], E12 and E13 (CNA) witnessed E11 (CNA) touch R8 inappropriately.</p> <p>1/7/19 (approximately 2:30 PM) - Documentation in the facility reported incident report revealed that E2 (DON) and E3 (RNAC) became aware of the alleged abuse reported by E12 (CNA).</p> <p>1/7/19 (4:57 PM) - The allegation of abuse for (R8) was reported to the State Agency approximately 14 hours after the alleged incident.</p> <p>1/10/19 - The facility did not report the allegation to the police until after the State Agency investigator was in the building.</p>	F 609	<p>all staff on the reporting guidelines for the State of Delaware and the updated Springpoint policy and procedure regarding abuse. Staff was educated on the urgency of reporting abuse immediately as all abuse incidents must be reported to the State within 2 hours. The Human Resource/Staff Educator/Designee will provide Abuse education for all new employees during their orientation. The Human Resource/Staff Educator/Designee will conduct Quarterly staff education for current employees regarding the abuse policy and Delaware guidelines for reporting abuse. The resident abuse policy has been updated to reflect the guidelines for the state. (See attachment 1) Administrator/Designee will conduct an audit of all reportable events for accuracy and timeliness. (See attachment 2)</p> <p>D. Success Evaluation The audit for accuracy and timeliness will be conducted weekly for 4 weeks or until 100% compliance is attained for 4 consecutive weeks, then monthly for 3 months or until 100% compliance is attained. DON/Designee will review all events, which will be reported on monthly QAPI. All reportable events are reported quarterly to the Professional Services Committee.</p>	

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F 609	<p>Continued From page 19</p> <p>4/5/19 (9:55 AM) - In an interview with E2 (DON), E2 reported that the reason why E12 (CNA) did not report what he/she had witnessed the same day as it occurred was related to he/she had reported E11 (CNA) for other things at another facility. E2 stated that E12 reported that at the other facility that nothing was done about it. E2 (DON) stated what E12 had witnessed with E11 really bothered E12, so E12 thought that she needed to report it the next day.</p> <p>E12 (CNA) and E13 (CNA) failed to identify E11's (CNA) actions towards R8 as alleged abuse, which resulted in the failure to immediately report the allegations of abuse.</p> <p>2. 5/16/16 - R2 was admitted to the facility with Alzheimer's dementia.</p> <p>11/6/18 - A Quarterly MDS revealed that R2 was severely cognitively impaired and required extensive assistance for her care.</p> <p>1/25/18 - R2's Care Plan included: "I yell and scream and cry out inappropriate verbalizations. I wander around the health care center. I can get angry, aggressive and frustrated because I cannot express myself." These behaviors per the facility's policy put R2 at risk for abuse.</p> <p>2/6/19 (9:51 AM) - An incident report submitted to the State Agency (on 2/7/19) revealed that E17 (Housekeeper) witnessed alleged physical and emotional abuse towards a resident.</p> <p>2/7/19 - A written statement from E17 (housekeeping) documented, "(E14, CNA) was saying inappropriate language to (R2). (E14) said, you f***** sh** on yourself. You're a nasty a\$\$." (E14) also snatched her gown very hard from her</p>	F 609		

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085053	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/08/2019
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F 609	<p>Continued From page 20</p> <p>neck. I was standing outside of bathroom after cleaning it. (E14's) back was facing me, so she didn't see me."</p> <p>2/7/19 (10:30 AM) - In the timeline of the Internal Report of Investigation provided to the surveyor by E3 (RNAC) it was documented that E3 became aware of the alleged abuse from E17 (Housekeeper).</p> <p>2/7/19 (4:09 PM) - E3 (RNAC) reported the allegation of abuse of R2 to the State Agency approximately 16 hours after the alleged incident.</p> <p>2/7/19 (5:43 PM) - A progress note written by E3 (RNAC) included: "An Incident of alleged abuse was reported to this nurse this AM by housekeeping staff. Incident happened on 2/6/19 at 9:51 AM."</p> <p>4/3/19 (3:10 PM) - E5 (RN Corporate Regional Nurse) and E2 (DON) confirmed that the 2/6/19 (9:51) AM incident was not submitted to state agency until 2/7/19 at 4:09 PM.</p> <p>4/3/19 (3:15 PM) - In an interview with E17 (housekeeping), E17 confirmed that she did not report the incident until the morning of the next day (meaning 2/7/19). E17 confirmed that her statement and the investigator's interview were correct. E17 confirmed that inappropriate language was used by E14 (CNA) and the reason that she reported it was that E14 ripped the gown off of R2 while it was snapped, and it had to have hurt R2.</p> <p>4/5/19 (9:50 AM) - In an interview with E3 (RNAC), E3 stated that "the reason why E17 (Housekeeper) did not report the alleged abuse that day was because she thought she had to</p>	F 609		

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F 609	Continued From page 21 report it to (E2, DON) and did not find her. (E3) commented that some of the CNA's encouraged her to report (the allegation of abuse), and that is when (E17) came to me." E17 (Housekeeper) failed to identify the actions of E14 (Hospice CNA) toward R2 as an allegation of abuse and resulted in not immediately reporting the alleged abuse to the State Agency. These findings were reviewed with E2 (DON), E3 (RNAC), E7 (SW), E15 (RN Supervisor), E5 (Corporate Clinical Consultant) and E4 (Clinical Analysis - CIS) on 4/8/19 during the exit conference beginning at 10:35 AM.	F 609			
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2) For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and	F 690		4/30/19	

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F 690	<p>Continued From page 22</p> <p>(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.</p> <p>§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on clinical record review and interview, it was determined that for one (R3) out of eight sampled residents, the facility failed to provide treatment and services to an indwelling catheter based on the plan of care. Findings include:</p> <p>Cross refer F585 #3.</p> <p>Review of R3's clinical record revealed:</p> <p>5/28/18 - R3 was admitted to the facility.</p> <p>6/17/18 - A care plan problem initiated for "I am at risk for infection related to indwelling catheter". Interventions effective 6/17/18 to present included "change Foley and drainage bag monthly and prn".</p> <p>2/26/19 - A quarterly MDS revealed R3 had a BIMS of 15 (cognitively intact) and a urinary catheter.</p> <p>1/24/19 - A physician order to "change Foley catheter every 30 days per Urologist."</p> <p>4/4/19 at 8:30 AM - During a medication</p>	F 690	<p>A. Resident R3s catheter was changed on 4/4/2019 upon discovery that it had exceeded the order date from the urologist.</p> <p>B. All residents have the potential to be affected by the deficient practice.</p> <p>C. A root cause analysis revealed that the nurse failed to follow the appropriate process of discontinuing a treatment order when an order is still applicable and appropriate for the resident's plan of care who has a foley catheter. A focused chart review was conducted for all residents who currently have a foley catheter specifically to ensure that all orders pertaining to the use, drainage, catheter change orders are present and accurate. The urologist was notified of the error and a new order was obtained by the medical director on 4/4/2019 to change the resident's foley catheter every 30 days as recommended. Education for the nursing staff on how to correctly transcribe and discontinue treatment orders was initiated on 4/8/19. The DON or designee will continue with a formal in-service for all</p>		

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F 690	<p>Continued From page 23</p> <p>administration observation of E8 (LPN), R3 stated that for the past five days he/she has been asking the nurses to check the computer because his/her catheter is over due to be changed.</p> <p>4/4/19 at 4:30 PM - During an interview, E9 (Charge RN) verified that R3's foley catheter was last changed 34 days ago and that the way the order was entered into the EMR (electronic medical record) did not trigger to the TAR (treatment administration record) to remind the nurses to change it every 30 days. E9 stated she corrected the order and will change R3's Foley catheter today.</p> <p>4/4/19 at 7:00 PM - A physician order to "change Foley catheter every 30 days per Urologist."</p> <p>4/4/19 at 7:13 PM - A nursing progress note by E9 (Charge RN) documented that: "Resident stated that (his/her) F/C (Foley Catheter) hasn't been changed and is over due to be changed, (R3) states 'It was due to be changed on 4/1/19!' and showed this RN (his/her) calendar. (E16 MD) in to see resident and aware. NON (new order noted) - change F/C (Foley Catheter)...q (every) 30 days...F/C (Foley Catheter) changed at this time without difficulty..Resident tolerated well."</p> <p>These findings were reviewed with E2 (DON), E3 (RNAC), E7 (SW), E15 (RN Supervisor), E5 (Corporate Clinical Consultant) and E4 (Clinical Analysis - CIS) on 4/8/19 during the exit conference beginning at 10:35 AM.</p>	F 690	nurses on 4/30/2019 and as needed during monthly nursing meetings D. The Nursing Supervisor will conduct audits of catheter orders to ensure that the orders are appropriate and implemented. The audits will be done weekly x 4 weeks until 100% compliance is achieved and monthly audits thereafter for the next 6 months or until 100% compliance is attained. The DON will report the data and outcomes of the audits to the QAPI committee monthly.		



DELAWARE HEALTH AND SOCIAL SERVICES

Division of Long Term Care
Residents Protection

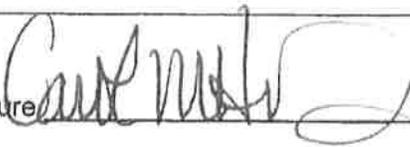
DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: The Moorings at Lewes

DATE SURVEY COMPLETED: April 8, 2019

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
3201 3201.1.0 3201.1.2	<p>The State Report incorporates by reference and also cites the findings specified in the Federal Report.</p> <p>An unannounced complaint survey was conducted at this facility from April 2, 2019 through April 8, 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 37. The survey sample totaled eight (8).</p> <p>Regulations for Skilled and Intermediate Care Facilities</p> <p>Scope</p> <p>Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.</p> <p>This requirement is not met as evidenced by: Cross refer to CMS 2567-L survey completed April 8, 2019: F585, F600, F607, F608, F609, and F690</p>	<p>This plan of correction has been prepared to the provisions of both Federal and State laws. Preparation and/or execution of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies.</p> <p>Cross reference ePOC dated 4/8/2019</p>	<p>4/30/2019</p>

Provider's Signature  Title Executive Director Date 4/30/2019