DELAWARE HEALTH AND SOCIAL SERVICES

Division of Health Care Quality

Office of Long Term Care Residents Protection

DHSS - DHCQ
263 Chapman Road, Ste 200, Cambridge Bldg.
Newark, Delaware 19702
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: The Center at Eden Hill

DATE SURVEY COMPLETED: June 13, 2024

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced Annual Complaint and Emergency Preparedness Survey was conducted at this facility from June 6, 2024 through June 13, 2024. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documents, as indicated. The facility census on the day of the survey was sixty-nine. The survey sample totaled forty-five (45) residents.	A. E6 was placed on administrative leave, and unable to work at the facility, until the appropriate updated tuberculosis screening results, criminal background check, mandatory drug testing and adult abuse registry check were received from A2 on 6/24/24. B. An audit was completed on 6/17/24 by the Human Resources Director to ensure all agency personnel working in the facility has background checks and mandatory screenings from the agency that they are currently employed with. C. A root cause analysis determined that the facility did not identify an agency employee who switched staffing agencies during their working tenure in the facility. Because of this, an updated personnel file, to include all mandatory screenings and background checks was not requested, nor kept on file. Education will be provided to the Human Resources Department as well as all staffing agencies contracted with the facility about background checks and mandatory screenings for all employees, even those working in the facility who are new to the agency. Education will be provided by the Executive Director or designee by 8/1/24. All	08/01/2024
3201	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.0	**Scope**		
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** This requirement is not met as evidenced by: Cross Refer to the CMS-2567-L completed June 6, 2024: cross refer: F656, F677, F684, F695 and F758.		
3201.5.0	**Personnel/Administrative**		

Provider's Signature B.Z5 Title Executive Director Date 7/1/24

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3201.5.5	**The facility shall have written personnel policies and procedures. Personnel records shall be kept current and available for each employee, and include the following:**	newly contracted agencies will also be educated at the time the agency/facility agreement is signed.	
3201.5.5.1	**Results of tuberculosis screening**	D. Human Resources Director or designee will complete a daily audit of a sample of 5 agency employees to ensure all employees have up to date mandatory screenings and background checks. A daily audit will continue until 100% compliance is achieved for 3 consecutive audits. Then, a three times weekly audit will be completed for a 5 employee sample until 100% compliance is achieved for 3 consecutive audits. Finally, a weekly audit will be completed for a 5 employee sample until 100% compliance is achieved for 3 consecutive audits. The QAPI committee will then complete a final audit in the following month's QAPI meeting to conclude that the problem was successfully addressed.	
3201.5.5.3	**Results of criminal background check**		
3201.5.5.4	**Results of mandatory drug testing**		
3201.5.5.5	**Result of Adult Abuse Registry check**		
	This requirement was not met as evidenced by: Based on interview and review of facility documentation, it was determined that for one (E6) out of eight employees reviewed, the facility's personnel records lacked evidence of the mandatory screenings. Findings include: 6/7/24 at 3:21 PM – In an email correspondence, the surveyor requested evidence of the above information from E1 (NHA) for E6 (Agency RN). 6/13/24 – Review of E6's personnel records revealed that E6's first day in the facility assigned as an agency RN for A2 (Staffing Agency) was on 8/15/21. Further review of E6's pre-employment records revealed tuberculosis screening results, criminal background checks, mandatory drug testing and adult abuse registry checks from A1 (Staffing Agency). There was a lack of evidence that E6's mandatory screening when hired by A2 was found on E6's personnel file. 6/13/24 9:20 AM – During an interview, E1 (NHA) stated that E6 has been assigned to work as RN in the facility for "over a long		

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	time under a different agency [A1]." E1 also stated that E6 recently changed agency employer sometime in February this year (2024). E1 stated, "... I'm not quite sure on the exact date on when he started working for [A2], I still will have to check." E1 further confirmed that the facility failed to obtain E6's updated personnel records from [A2]. 6/13/24 9:25 AM – In an interview, E4 (HR Director) stated that E6's first day in the facility on file was 8/15/21 when E6 was under the former employer [A1]. E4 confirmed that E6's personnel records on file were the mandatory screenings provided by [A1] when E6 first started reporting to work in the facility "many years ago. " 6/13/24 2:30 PM – During an interview, E2 (DON) stated that the facility started to be in contract with Reliance in February 2024. E2 further stated, "... I really do not know the exact date when he switched to [A2]. Maybe on February 23, 2024 when we started our contract with [A2]." Findings were reviewed during the exit conference on 6/13/24 at 2:30 PM with E1 (NHA) and E2 (DON).		

Provider's Signature ______________________ Title ______________________ Date ______________

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	085057	A. BUILDING ______ B. WING ______	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTER AT EDEN HILL, LLC	300 BANNING STREET DOVER, DE 19904

(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 June 6, 2024 through June 13, 2024. The facility census was 69 on the first day of the survey. In accordance with 42 CFR 483.73, an Emergency Preparedness survey was also conducted by The Division of Health Care Quality, the Office of Long-Term Care Residents Protection at this facility during the same time period. Based on observations, interviews, and document review, no Emergency Preparedness deficiencies were identified.	E 000		
F 000	INITIAL COMMENTS An unannounced Annual and Complaint Survey was conducted at this facility from June 6, 2024 through June 13, 2024. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census on the first day of survey was 69. The investigative sample totaled 45 residents. ADON - Assistant Director of Nursing; CNA - Certified Nurse's Aide; DON - Director of Nursing; FM - Family Member; LPN - Licensed Practical Nurse; NHA - Nursing Home Administrator; RN - Registered Nurse; UM - Unit Manager; Abnormal Involuntary Movement Scale (AIMS) - An assessment/test to identify involuntary movements that developed as a result of use an antipsychotic medications;	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 07/01/2024

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 Antipsychotic - Class of medication used to manage psychosis, an abnormal condition of the mind involving a loss of contact with reality and other mental and emotional conditions. Brief Interview for Mental Status (BIMS) - test to measure thinking ability with score ranges from 0 to 15. 13-15: Cognitively intact 8-12: Moderately impaired 0-7: Severe impairment; Hypoxia; deficiency in amount of oxygen reaching body tissues. MAR - Medication Administration Record; Medication Regimen Review (MRR) - A review of resident medications completed by a pharmacist monthly and on admission to identify potential concerns. Any concerns or recommendations are noted for review by a physician; Minimum Data Set (MDS) - A standardized set of assessments completed in nursing homes; Pulse Oximetry - Measures blood oxygen saturation levels - desired range 94% to 100%; Titrating - Adjusting oxygen flow rate.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §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	F 656		8/1/24

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F 656	Continued From page 2 or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it has been determined that for one (R46) out of forty five residents reviewed for care plans, the facility failed to develop a care plan to address wax build up in the ears. Findings include:	F 656	A. A person centered care plan was created for R46 on 6/25/24 to address the wax buildup in his ear. B. A facility wide audit was completed on	

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F 656	Continued From page 3 5/18/24 - R46 was admitted to the facility. 5/31/24 11:00 AM - A physician's order written for R46 documented, "Debrox Otic (relating to the ear) Solution 6.5% (Carbamide Peroxide) Otic instill five drop (sic) in both ears two times a day for earwax for five days flush with warm water on the fifth day." 6/7/24 10:53 AM - A physician's order written for R46 documented, "Debrox Otic (relating to the ear) Solution 6.5% (Carbamide Peroxide) Otic instill five drop (sic) in both ears two times a day for earwax for five days flush with warm water on the fifth day." 6/13/24 10:30 AM - Further review of R46's clinical record lacked evidence that a person centered care plan had been created to address the wax build up in R46's ear. 6/13/24 10:45 AM - During an interview E19 (RN, UM) confirmed that a care plan had not been created for wax build up in R46's ear. Findings were reviewed during the exit conference on 6/13/24 at 2:30 PM with E1 (NHA) and E2 (DON) and representatives with the Ombudsman office.	F 656	6/25/24 to ensure that any resident in the facility that is receiving otoscopic treatment has a corresponding patient centered care plan. C. A root cause analysis determined that the facility did not create a person centered care plan for R46 due to a lack of a system in place to audit all medical treatment changes and ensure corresponding care plans are created. On 6/14, a system was put in place where the Director of Nursing or designee, in coordination with the IDT team, will review all medical treatment changes each morning and ensure that they have a corresponding care plan. The Staff Development Coordinator or designee will educate all nursing staff on the new process by 8/1/24. The Staff Development Coordinator will also ensure that all new hires are educated on the updated process and the importance of person centered care plans as part of the clinical orientation. D. The Nursing Supervisor or designee will complete a daily audit of a sample of 5 residents to ensure any patients with recent changes to their medical treatments have corresponding care plans. A daily audit will continue until 100% compliance is achieved for 3 consecutive audits. Then, a three times weekly audit will be completed for a 5 resident sample until 100% compliance is achieved for 3 consecutive audits. Finally, a weekly audit will be completed for a 5 resident sample until 100% compliance is	

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F 656	Continued From page 4	F 656	achieved for 3 consecutive audits. The QAPI committee will then complete a final audit in the following month's QAPI meeting to conclude that the problem was successfully addressed.	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that for one (R3) out of three residents reviewed for ADL (Activities of Daily Living) the facility failed to provide nail care. Findings include: A facility policy and procedure titled, "Dignity" updated, 3/14/24 documented: Patients shall receive assistance with activities of daily living (ADLs) every shift, as appropriate. ADLs include bathing, grooming, dressing, eating, oral hygiene, ambulation, toilet activities and trimming of toenails. Review of R3's clinical record revealed: 5/15/24 - R3 was admitted to the facility. 5/15/24 - Review of R3's care plan for ADL's revised 5/26/24 documented interventions included provide assistance as needed with grooming, bathing, and personal hygiene and per patient's preferences and R3 required an assist of one for grooming and personal hygiene. Further	F 677	A. R3's fingernails were trimmed and cleaned on 6/11/24. B. A facility wide audit of all residents was completed on 6/26/24 to identify any other residents who were in need of nail care. Nail care was performed on the identified residents on 6/26/24. C. A root cause analysis determined that nursing staff was not properly assessing each patients need for nail care during their shift. The Staff Development Coordinator or designee will provide education to all nursing staff that all patient's fingernails should be inspected each shift, then cleaned and trimmed if necessary by 8/1/24. The Staff Development Coordinator will also include the importance of nail care, and the facility policy in the clinical portion of orientation for all new hires. D. Nursing supervisor or designee will	8/1/24

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F 677	Continued From page 5 review of R3's care plan lacked evidence that R3 had refused nail care. 5/17/24 - Review of R3's care plan for confusion/forgetfulness revised 5/26/24 documented interventions included assist as needed. 5/20/24 - An admission MDS assessment revealed R3 was moderately cognitively impaired. R3 required substantial maximum assist of one for showers and bathing and partial moderate assist of one for toileting. 6/6/24 10:30 AM - A random observation of R3's hands revealed dark encrusted debris underneath each fingernail on the right and left hand. Additionally, R3's fingernails were long and needed to be trimmed on both hands. 6/7/24 9:36 AM - During a telephone interview R3's FM1 stated, "I have asked them a couple of times to cut them, but the staff just take their time doing things." 6/10/24 9:40 AM - A second observation revealed R3's fingernails on the right and left hand had not been cut and R3 continued to have dark encrusted debris underneath his fingernails. 6/10/24 10:52 AM - During an observation E20 (CNA) entered R3's room. E20 asked [R3], "are you ready to get washed up." [R3] said, "yes". E20 then left R3's room. 6/10/24 10:55 AM - E20 was observed entering R3's room to provide care. 6/10/24 11:09 AM - During an interview E20	F 677	complete a daily audit of a sample of 5 residents to ensure their nails are sufficiently cleaned and trimmed. A daily audit will continue until 100% compliance is achieved for 3 consecutive audits. Then, a three times weekly audit will be completed for a 5 resident sample until 100% compliance is achieved for 3 consecutive audits. Finally, a weekly audit will be completed for a 5 resident sample until 100% compliance is achieved for 3 consecutive audits. The QAPI committee will then complete a final audit in the following month's QAPI meeting to conclude that the problem was successfully addressed.	

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F 677	Continued From page 6 stated, "Usually I do nail care if I see that a resident's fingernails are physically dirty, and they need to be cut or if they ask me to while I am doing care, then I would do nail care." 6/10/24 2:10 PM - R3's fingernails remained long on both hands with dark encrusted debris underneath his fingernails on both hands. 6/11/24 8:30 AM - R3's fingernails had not been cut and continued to have dark encrusted debris underneath his fingernails on both hands. 6/11/24 8:33 AM - During an interview and observation E19 (RN, UM) stated, "Usually they do an assessment of the nails to see if they need to be cut or when the resident gets their shower." E20 confirmed R3's fingernails were dirty and needed to be cut. E20 updated the staff and requested that R3 be provided nail care. The facility failed to provide appropriate support and assistance for R3's personal hygiene and grooming when the facility failed to cut and trim R3's fingernails in accordance with R3's documented plan of care. Findings were reviewed during the exit conference on 6/13/24 at 2:30 PM with E1 (NHA) and E2 (DON) and representatives from the Ombudsman.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive	F 684		8/1/24

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F 684 Continued From page 7

assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.
This REQUIREMENT is not met as evidenced by:
Based on interview and record review it was determined that for one (R46) out of one resident reviewed for hearing the facility failed to administer ear drops as ordered by the physician for wax build up in R46's ears. Findings include:

R46's clinical record revealed;

5/18/24 - R46 was admitted to the facility.

5/18/24 - A hospitalist progress note documented R46, had left ear pain deep-seated cerumen (wax build up) status post (treated) Debrox (ear wax removal drops).

5/20/24 - A physicians encounter note documented R46, had ear wax and was treated.

5/22/24 - An admission MDS (Minimum Data Set) revealed that R46 was cognitively intact.

5/31/24 11:00 AM - A physician's order written for R46 documented, "Debrox Otic (relating to the ear) Solution 6.5% (Carbamide Peroxide) Otic instill five drop (sic) in both ears two times a day for earwax for five days flush with warm water on the fifth day."

6/6/24 11:38 AM - During an interview R46 stated, "I have an ear infection and I can't sleep at night because of the pain in my left ear." R46 then said, "I have told them, but they are not doing anything

F 684 (Provider's Plan of Correction)

A. On 6/7/24, the nurse practitioner re-ordered the Debrox Otic Solution, which was administered in accordance to the provider's order until 6/12/24.

B. A facility wide audit of all medication administration records (MARs) was completed by the Director of Nursing on 6/12/24 to ensure that there are no unsupervised self-administration (U-SA) orders.

C. A root cause analysis determined that the nursing staff was unable to sign off on R46's Debrox orders because it was entered by the provider as an "unsupervised, self-administration" (U-SA) order. In an interview with the nurse practitioner who entered the order, she was unaware that she selected the (U-SA) option. She stated that it must have occurred on accident while entering the order in PCC. As a result, the Director of Nursing or designee will educate all ordering providers by 8/1/24 on refraining from using the (U-SA) code when entering orders in the medical record, unless the patient is expected to self-administer the medication. In addition, Staff Development Coordinator or designee will educate all nursing staff on how to identify U-SA orders and the process to clarify

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F 684	Continued From page 8 about it." 6/7/24 10:53 AM - A physician's order written for R46 documented, "Debrox Otic (relating to the ear) Solution 6.5% (Carbamide Peroxide) Otic instill five drop (sic) in both ears two times a day for earwax for five days flush with warm water on the fifth day." 6/10/24 10:29 AM - During an interview E21 (RN) stated, "[R46] complained about ear pain about two weeks ago, that was the last time I was here. E21 stated, "[R46] has pain medication and he is on Debrox ear drops, now. E21 also stated, "[R46] has Melatonin (Sleep Aid) to sleep at night." 6/11/24 11:00 AM - An interview with E19 (RN UM) confirmed R46 had not been administered Debrox ear drops as ordered 5/31/24 through 6/5/24. E19 confirmed the coding used on R46's MAR (Medication Administration Record) was not a code E19 was familiar with. E19 stated, "When a medication has been administered by the nurse you will see the nurses' initial and a check mark on the MAR." Additionally, E19 stated, "I do not recognize this chart code U-SA this is the first time I have seen this on a MAR." 6/12/24 12:11 PM - A telephone interview with CH1 (Consultant Pharmacist) revealed that Debrox ear drops were delivered to the facility for R46 on 5/31/24 and signed for at 6:24 PM. 6/12/24 1:00 PM - During an interview and observation E2 (DON) stated, "I do not recognize the code U-SA on R46's MAR for Debrox ear drops."	F 684	and correct any identified deficient orders by 8/1/24. Staff Development Coordinator or designee will also include identifying U-SA orders in the clinical orientation provided to new hires in the nursing department. D. Nursing supervisor or designee will complete a daily audit of a sample of 5 residents MARs to ensure no inappropriate U-SA orders have been entered. A daily audit will continue until 100% compliance is achieved for 3 consecutive audits. Then, a three times weekly audit will be completed for a 5 resident sample until 100% compliance is achieved for 3 consecutive audits. Finally, a weekly audit will be completed for a 5 resident sample until 100% compliance is achieved for 3 consecutive audits. The QAPI committee will then complete a final audit in the following month's QAPI meeting to conclude that the problem was successfully addressed.	

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	085057	A. BUILDING ______ B. WING ______	C 06/13/2024

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F 684	Continued From page 9 6/12/24 3:49 PM - Another interview with E2 confirmed, "I can't provide you with the documentation that R46's ear drops were administered 5/31/24 through 6/5/24 as ordered." The facility failed to ensure that R46 received care and services to aid in the treatment of excessive wax build up and ear discomfort which affected the residents daily living. Findings were reviewed during the exit conference on 6/13/24 at 2:30 PM with E1 (NHA) and E2 (DON) and representatives with the Ombudsman office.	F 684		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, it was determined that for one (R51) out of one resident sampled for respiratory care, the facility failed to provide respiratory care consistent with professional standards of practice. Findings include: Review of R51's clinical record revealed: 5/1/24 - R51 was admitted to the facility with	F 695	A. Physician order for oxygen therapy was transcribed in the electronic medical record (EMR) for R51 on 6/10/24. B. On 6/26/24, a facility wide audit was completed on all patient charts to ensure that all patients who require oxygen therapy have a corresponding oxygen order.	8/1/24

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F 695

Continued From page 10
multiple diagnoses including a sudden onset of respiratory failure with hypoxia (low oxygen level reaching the body tissues).

5/6/24 - R51's Admission MDS assessments revealed that R51 was moderately cognitively impaired and was not on oxygen therapy.

5/12/24 - R51 was care planned for alteration in respiratory status/difficulty in breathing related to sudden onset respiratory failure with hypoxia. Interventions including but not limited to providing oxygen as ordered.

5/29/24 12:31 PM - A nurse progress note documented, "...patient is on 4L/min (liters/min) oxygen due to fluctuating O2 Sat (oxygen saturation or level) between 89% to 91% RA (room air)..."

5/31/24 1:00 AM- A physician encounter note documented, "Pulse Oximetry (measures blood oxygen saturation levels - desired range 94% to 100%) on RA was 97% on 5/31/24 8:25 PM, "...Patient also requested to start titrating (continuously measure and adjust the oxygen flow rate) patient off of oxygen..."

6/5/24 1:06 PM - Nurse progress notes documented R51 had a respiratory concern and shortness of breath with exertion and was on 2 L/min oxygen therapy.

6/6/24 10:53 AM - R51 was observed sitting in her wheelchair with oxygen in use at 3L/min via nasal canula.

6/8/24 2:54 PM - A nurse progress note documented that R51 had a respiratory concern

F 695

C. A root cause analysis determined that PRN oxygen orders should have been transcribed in R51's EMR at the time of the nursing assessment on 5/1/24. Staff Development Coordinator or designee will educate all nursing staff on ensuring that all residents who require oxygen have corresponding oxygen orders in the medical record by 8/1/24. Staff Development Coordinator or designee will also include auditing and transcribing oxygen orders into the clinical orientation process for any new hires in the nursing department.

D. Nursing supervisor or designee will complete a daily audit of a sample of 5 residents to ensure all residents using oxygen have a corresponding physician order. A daily audit will continue until 100% compliance is achieved for 3 consecutive audits. Then, a three times weekly audit will be completed for a 5 resident sample until 100% compliance is achieved for 3 consecutive audits. Finally, a weekly audit will be completed for a 5 resident sample until 100% compliance is achieved for 3 consecutive audits. The QAPI committee will then complete a final audit in the following month's QAPI meeting to conclude that the problem was successfully addressed.

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F 695	Continued From page 11 and shortness of breath with exertion and was on 2 L/min oxygen therapy. 6/9/24 7:28 PM - A nurse progress note documented that R51 was on oxygen therapy at 4L/min. 6/10/24 10:54 AM - During a random observation, R51 was observed with oxygen in use at 4L/min via nasal canula. 6/10/24 - A review of R51's physician's order revealed a lack of evidence of R51's oxygen therapy via nasal cannula (NC). 6/10/24 11:56 AM - During an interview, E5 (LPN) confirmed that R51 did not have a physician's order for her oxygen therapy. In addition, E5 stated, "...[R51] still requires oxygen therapy because her oxygen level at room air drops between 89%-90% when we titrate it"..."We will fix the physician's order and have it clarified." 6/12/24 3:50 PM - Findings were discussed with E2 (DON). E2 confirmed that R51 did not have a physician's order for her oxygen therapy until the surveyor brought it to the facility's attention. E2 presented to the surveyor a copy of R51's new physician order for oxygen therapy dated 6/10/24. Findings were reviewed during the exit conference on 6/13/24 at 2:30 PM with E1 (NHA) and E2 (DON) and representatives with the Ombudsman office.	F 695		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs.	F 758		8/1/24

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F 758	Continued From page 12 §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and	F 758		

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F 758	Continued From page 13 indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for one (R40) out of five residents reviewed for unnecessary medication review the facility failed to ensure adequate monitoring of antipsychotic medication was completed. Findings include: The facility policy on antipsychotic medication use last updated 2/13/24 indicated, "AIMS evaluation to be completed within 14 days of admission, then should also be evaluated for tardive dyskinesia at least every six months. 5/22/24 - R40 was admitted to the facility with multiple diagnoses including, unspecified dementia, psychotic disturbance, and mood disturbance. 5/22/24 - A physicians order was written for R40 to receive an AIMS testing/assessment every 180 days. 5/23/24 - An MRR was completed for R40 with a recommendation that indicated, resident is currently receiving an antipsychotic and requires an AIMS test at baseline and every six months thereafter. The MRR was signed as recognized the same date. 5/25/24 - An admission MDS assessment	F 758	A. An AIMS evaluation was completed for R40 on 6/10/24. B. A facility audit for all patients on antipsychotics was completed on 6/25/24 by the Director of Nursing to ensure all patients taking antipsychotics received an AIMS assessment. C. A root cause analysis determined that the nurse responsible for completing the assessment signed "no" instead of completing the AIMS assessment. The Staff Development Coordinator or designee will provide education to all nursing staff that all residents are to receive an AIMS evaluation within 14 days of admission, and that "no" is not an appropriate response to the evaluation. Education will be completed by 8/1/24. Staff Development Coordinator or designee will also include education regarding the AIMS assessment in the clinical orientation for new hires in the nursing department. D. Nursing supervisor or designee will complete a daily audit of a sample of 5 residents to ensure AIMS evaluations have been completed. A daily audit will	

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F 758	Continued From page 14	F 758		

documented that R40 received antipsychotic medications.

6/1/24 - A care plan for use of antipsychotic medications was created for R40 that included the interventions to complete an AIMS test on admission and as needed. Monitor side effects as needed.

6/10/24 8:15 AM - The surveyor requested an copy of R40's most recent AIMS test. Simultaneously review of R40's medical record, including MAR and progress notes lacked evidence of daily side effect monitoring related to the use of antipsychotic medications.

6/10/24 10:25 AM - An AIMS assessment was completed for R40 and then submitted to the surveyor.

During an interview on 6/10/24 at 12:14 PM, E19 (RN) and unit manager for R40's unit confirmed the finding. E19 stated that AIMS testing is completed, "Close to admission then every six months". E19 visualized R40's MAR and confirmed daily monitoring for side effects related to antipsychotic medication was mistakenly absent.

Findings were reviewed during the exit conference on 6/13/24 at 2:30 PM with E1 (NHA) and E2 (DON) and representatives with the Ombudsman office.

continue until 100% compliance is achieved for 3 consecutive audits. Then, a three times weekly audit will be completed for a 5 resident sample until 100% compliance is achieved for 3 consecutive audits. Finally, a weekly audit will be completed for a 5 resident sample until 100% compliance is achieved for 3 consecutive audits. The QAPI committee will then complete a final audit in the following month's QAPI meeting to conclude that the problem was successfully addressed.