STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	085032		C 02/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMINSTER VILLAGE HEALTH	1175 MCKEE ROAD DOVER, DE 19904

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F 000	INITIAL COMMENTS An unannounced annual & complaint survey was conducted at this facility from January 31, 2018 through February 12, 2018. The deficiencies contained in this report are based on observations, interviews, reviews of residents' clinical records and other facility documentation as indicated. The facility census the first day of the survey was 34. The survey sample totaled thirty-four (34). Abbreviations/Definitions used in this report are as follows: NHA - Nursing Home Administrator; DON - Director of Nursing; ADON - Assistant Director of Nursing; ED - Executive Director; ADD - Assistant Dietary Director; DSS - Director of Social Services; RCN - Regional Corproate Nurse; RN - Registered Nurse; LPN - Licensed Practical Nurse; UM - Unit Manager; LDN-Licensed Dietary Nutritionist; MD - Medical Doctor; RD - Registered Dietician; OT-Occupational Therapist; RNAC - Registered Nurse Assessment Coordinator; RDD - rehabilitation department director; CNA - Certified Nurse's Aide; CN - Charge Nurse FSD - Food Service Director; NP - Nurse Practitioner; PA - Physician Assistant; SW - Social Worker; % - symbol for percentage;	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/08/2018

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 < - symbol for less than; > - symbol for greater than; Abilify - antipsychotic medication; Accucheck - blood glucose monitor used to check blood sugar levels; ADL - activities of daily living; Antidiabetic - a medication that helps lower blood sugar; Antipsychotic - drug to treat psychosis, other mental disorders; approx. - approximately; ARF - acute renal failure (kidneys not functioning properly); BID - Twice a day; 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; BMP - set of eight tests that measure blood sugar and calcium levels, kidney function, and chemical and fluid balance; BP - blood pressure - a vital sign; BUN - (Blood Urea Nitrogen)- a lab test that measures kidney function; BS-blood sugar; Buttocks-butt; Capillary - small blood vessel; Cardiologist - doctor who treats conditions related to the heart; Carvedilol - medication to treat high blood pressure and heart failure, CAT [CT] scan - a three-dimensional image of a cross section of the body made with x-rays that is useful in diagnosing disease; Celexa - antidepressant medication; CHF - Congestive Heart Failure - heart cannot	F 000		

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F 000	Continued From page 2 pump enough blood to meet body's needs; Cipro - an antibiotic, Cm - centimeter - unit of measurement; Coccyx - tailbone; Cognition - mental processes or thinking; Coma - a deep state of unconsciousness; Concomitant - accompanying; COPD - Chronic Obstructive Pulmonary disease - progressive lung disease that makes it hard to breathe; Creatinine - a blood or urine laboratory test used as a measurement of kidney function; Cyclosporine - a medication that diminishes the body's immune response, D5 - intravenous solution of Dextrose 5% in water used to treat low blood sugar (hypoglycemia); Deep Tissue Injury (DTI) - Purple or maroon intact skin or blood-filled blister. May start as tissue that is painful, mushy, firm, boggy (wet, spongy feeling), warmer or cooler than surrounding tissue; Delusions - false belief that is thought to be true; Dementia - a brain disorder with memory loss, poor judgement, personality changes and disorientation or loss of mental functions such as memory and reasoning that interfere with a person's daily functioning; Diaphoretic - sweating severely; Diuretic - medicine to reduce water/excess fluid in the body; DKA - Diabetic Ketoacidosis - a life threatening condition related to increased ketones in the body; dL - deciliter, form of measurement; DM - Diabetes mellitus - disease with high levels of sugar in the blood; DNR - Do Not Resuscitate; dx - diagnosis; ED - emergency department;	F 000		

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F 000	Continued From page 3 Edema - swelling; e.g.- for example; EKG - (electrocardiogram) - a picture of the hearts electrical activity; EHR - electronic health record; E-KIT - a device that dispenses single doses of medication; eMAR - Electronic Medication Administration Record (in the computer); EMR - Electronic Medical Record; EMR - Emergency Medical Response; EMS - Emergency Medical Services; ER - emergency room; Endocrinologist - doctor who treats conditions related to the endocrine system; Erosion - the gradual destruction of tissue; etc. (et cetera) - and so forth; FBS - fasting blood sugar; fingerstick-FS- FSBS- a test to determine blood sugar; Gel cushion - a seat cushion put in a wheelchair or a chair to relieve pressure and provide comfort; Glipizide - oral diabetic medication; Glucagon - emergency medication used to increase low blood sugar; Glucometer - machine used for testing blood sugar; Granulation - new tissue with blood vessels formed during wound healing; Hallucination - something that seems real but doesn't exist; Hematoma - a solid swelling of clotted blood within the tissues; HgbA1C - blood test that represents the average blood sugar concentrations in the person with diabetes for approximately the preceding 3 months; HS - At bedtime;	F 000		

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F 000	Continued From page 4 Hyperglycemia - high blood sugar; Hyperkalemia - high potassium; Hypertension - high blood pressure; Hypoglycemia - low blood sugar; Hypotension - low blood pressure; Humalog insulin - injected medication to control blood sugar; ID - interdisciplinary - multi-professional collaboration; IDT - ID team; ICU - intensive care unit; IMAR - electronic MAR; K+ - potassium; Ketones - a substance formed when the body breaks fat down for energy; Lab - laboratory; Laceration - a deep cut or tear in skin or flesh; Lasix - a medication that treats fluid retention, Lexapro - antidepressant medication; LOA - leave of absence; LTC - Long Term Care Unit; Lantus insulin - injected medication to control blood sugar; Levemir insulin - long acting medication injected to control blood sugar; MAR - Medication Administration Record; MDD - major depressive disorder; MDS (Minimum Data Set) - standardized assessment used in nursing homes; mg (milligrams) - metric unit of weight; meq - (milli-equivalents) - unit of measurement; meq/L - (milli-equivalents per liter) - a unit of measurement used for some medication dosages and to report some medical tests results; med - medicine; med pass-nutrition supplement; Metabolism - description of all chemical reactions involved in maintaining the living state of the cells and the organism;	F 000		

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F 000	Continued From page 5 Metformin - oral diabetic medication; Moderate Cognitive Impairment - decisions poor, cues / supervision required; Nasal cannula (NC) - a device used to deliver supplemental oxygen to a person via lightweight tube which splits into two prongs and is placed in the nostrils; Neuro Checks - Neurological assessments - series of questions and physical tests to see if the nervous system is impaired; usually documented on a flowsheet; Neurological - pertaining to the nervous system of the body; Nonpharm - interventions or therapy that does not involve drugs, such as music or massage. Novolog - a type of Insulin medication which is injected to rapidly control blood sugar levels; NSS - normal saline solution; Omni-cell - a machine that dispensed medications to authorized staff; Oxygen saturation - measures oxygen in blood; Paranoia - extreme fear or distrust; Parkinson's disease - progressive disease of the nervous system; po - by mouth; PO - Physician's Order; POS - Physician's Order Summary - periodic summary of current active physician's orders; Post - after; Potassium - a natural salt that is important for the heart, muscles, and nerves, Point of Care - electronic charting system for CNAs; PPE - (Personal protective equipment) - gloves, masks, clothing, goggles, or other garments or equipment designed to protect the wearer's body from infection. Pressure Ulcer (PU) -sore area of skin that develops when blood supply to it is cut off due to	F 000		

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F 000	Continued From page 6 pressure; Psychotropic medications - any medication capable of affecting the mind, emotions and behavior; Physician Order Sheet (POS) - monthly report of active physician orders; Psych - pertaining to psychology; pt - patient; PU - Pressure Ulcer - -sore area of skin that develops when blood supply to it is cut off due to pressure; Pulse ox - measures blood oxygen saturation levels - desired range 94% to 100%; PRN - As needed; q - every; qd - everyday; Remeron - antidepressant medication; ROHO cushion - a wheelchair seat cushion that provides pressure relief to help prevent skin breakdown or promote wound healing; Rollator - walker with wheels and a seat; RP - responsible party; SBAR (Situation, Background, Assessment, Recommendation) - tool to communicate with other members of the health care team; s/s - signs and symptoms; Sepsis - potentially deadly condition with whole-body inflammation; Skin prep - liquid dressing for intact skin to form protective film; Sacrum - large triangular bone at base of spine; sat's - Oxygen saturation - measures oxygen in blood; Stages (severity) of pressure ulcers (PUs): Stage I (1) - intact red skin often over a boney area that does not turn white/light (blanche) when pressed Stage II (2) - blister or shallow open sore with red/pink color	F 000		

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F 000	Continued From page 7 Stage III (3) - open sore that goes into the tissue under below the skin. How deep it is depends on the amount of tissue under the skin. Stage IV (4) - open sore so deep that muscle, tendon or bone can be seen/felt; Subcutaneous - injection given into the fat layer between the skin and the muscle; Sutures - stitches holding together the edges of a wound; Systolic BP (SBP)- top number of the blood pressure reading reflecting pressure in arterial vessels when the heart is beating; T&R - turn and reposition; TAR - treatment administration record; Trazodone - an antidepressant medication used to treat depression, anxiety and to help with sleep; U - units of measurement; Unstageable - actual depth of the ulcer cannot be determined due to the presence of slough (yellow, tan, gray, green or brown soft dead tissue) and/or eschar (hard dead tissue that is tan, brown or black). Eschar is worse than slough; Urethra - the duct by which urine is conveyed out of the body from the bladder; Urethral meatus - opening of urethra; Urinary Tract Infection - UTI- urine infection; UTA - unable to assess; VS - Vital signs; w/c - wheel chair; WNL - within normal limits; x - times. Zyrtec - a brand name of of a medication to treat cold and allergy symptoms.	F 000		
F 578	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v)	F 578		4/2/18

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F 578	Continued From page 8 §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the	F 578		

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F 578	Continued From page 9 appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for two (R34 and R32) out of 34 sampled residents the facility failed to ensure the that advanced directives were up to date and accurate in the clinical record. Findings include: 1. The following was reviewed in R32's clinical record: 9/21/16 - Green paper with "Full Code Instructions" on paper clinical record on 2/1/18. 12/28/17 - Hospice IDT care plan DNR - Nurse may pronounce on paper clinical record on 2/1/18. 1/3/18 - Comfort Care Worksheet Plan of Care Development documented: Advanced Directives reviewed - yes; family signed 1/3/18. 2/1/18 11:10 AM - Interview with E37 (LPN) revealed that she was surprised a full code sheet would be on R32's record. The electronic record documented the presence of a living will and no DNR form but E37 could not find a copy of the living will on the resident's record. E37 stated she would talk to the resident's responsible party (RP). 2/6/18 1:41 PM - Review of the paper clinical record revealed that the green "Full Code" had been replaced with a red "Do Not Resuscitate Instructions" dated 2/1/18. 2/6/1801:43 PM - Interview with E37 revealed that the responsible party came in to do the DNR	F 578	A. R34 & R32 code status has been reviewed and updated in the electronic pharmacy system to reflect current code status. B. An audit of current residents was completed on 2/9/18 to ensure that code status was reflected accurately and consistently in all locations. C. Nursing staff will be educated that code status will be documented in the electronic pharmacy record ancillary orders. This is the location that staff will reference to determine code status. Code status will be removed from other forms and areas of the medical record to avoid confusion. D. An audit of 5 residents will be completed weekly for 4 weeks and then monthly for 2 months to ensure that code status is reflected correctly in the electronic pharmacy record ancillary orders and does not conflict with other portions of the record. All audit results will be forwards to the Quality Assurance Process Improvement team for review and recommendations.	

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F 578	Continued From page 10 but did not bring the living will in with her. In front of the surveyor E37 called the RP to fax the living will. 2/6/18 2:35 PM - E37 showed the surveyor the living will dated 1/25/10. 2/7/18 around 9:30 AM - Review of the Advanced Directive Policy provided by the facility revealed it was for facilities in Pennsylvania. E1 (NHA) was present and stated he would talk to the corporate office. A short time later E1 stated the corporate office would develop a policy specific to Delaware.. 2. Review of R34's clinical record revealed the following: 12/22/17 - The Interdisciplinary Notes indicate a Risk Review meeting was held post admission to the hospital with acute respiratory failure and a full code Status was ordered. 6/12/17 - Electronic Medical Record (EMR) contained a Do Not Resuscitate (DNR) status. 12/26/17 - Full Code form signed 12/26/17 and found on the hard copy of the chart. 12/26/17 - Physicians orders located in the Electronic Medication Record (eMAR) indicate a Full Code status ordered. 2/9/18 at 2:52 PM - During an interview with E24 (LPN) who handles the Full Code and DNR. E24 revealed that the nurses ensure that code status is reflected in the hard copy chart and the physician's orders. The form is scanned in the EMR by clerical support staff. It was confirmed	F 578		

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F 578	Continued From page 11 that R17's record should reflect a full code status. 2/9/18 at 3:02 PM - E24 called E3 (ADON) to advise her of the issue and E3 assured that it would be fixed right away. Findings reviewed with E1, E2 (DON), E3, E20 (ED), and E32 (RCN) on 2/12/18 at approximately 4:00 PM. Severity/Scope = 2/1	F 578		
F 580	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.	F 580		4/2/18

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F 580	Continued From page 12 (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, interview, and review of other facility documentation as indicated, it was determined that the facility failed to immediately inform the resident's representative and failed to consult the resident's physician for one (R36) out of 34 sampled residents. R36 had a pressure ulcer (PU) that worsened to an unstageable with slough and the facility failed to inform the resident's representative and failed to consult the resident's physician. Findings include: Facility Policy and procedure titled, Change in Medical Condition, with initial creation date of 1/15/14, with a last approved date of 11/18/16 stated:	F 580	A. R36 is no longer in the facility. B. Current residents with wounds will be reviewed for timely physician notification and family notification for worsening of current wounds. C. Nursing staff will be educated on the need to do physician notification and family notification when there is deterioration or change in the wound requiring a treatment change. D. An audit of 5 residents with wounds will be completed to ensure timely physician and family notification for wound changes weekly for 4 weeks then monthly for 2 months. All audit results will be	

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F 580	Continued From page 13 The facility "...shall provide notice of change in condition related to but not limited to ...skin conditions..." Guidelines: 1. Facility must consult with competent resident and notify the physician, appropriate facility staff, responsible party or designated person if applicable, significant other, and/or power of attorney of the following: "...-Significant changes in resident's physical, mental, or psychological or social status..." Cross refer F686, example #1. Cross refer F711, example #1. Review of R36's clinical record revealed: 1/5/18 - Admitted to the facility from the hospital. 1/5/18 - Initial Nursing Assessment documented that R36 was admitted with one, stage II PU of the sacrum. 1/5/18 and timed 8:28 PM - Wound Rounds documentation, stated R36 was admitted with one, stage II PU of the sacrum (tail bone) measuring 1.0 cm. X 1 cm. X and less than 0.1 cm., with no pain. R36's daughter, R36's representative was at the bedside and was aware of R36's stage II PU. In addition, R36's physician, E9 was notified on 1/5/18 at 8:00 PM. 1/14/18 and timed 9:20 AM - Wound Rounds documentation stated, stage II PU of the coccyx, the tail bone area, measuring 2.0 cm. X 1.4 cm. X and less than 0.1 cm., with no pain. 1/23/18 and timed 7:11 PM - Wound Rounds documentation stated coccyx measuring 2.2 cm.	F 580	forwards to the Quality Assurance Process Improvement team for review and recommendations.	

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F 580	Continued From page 14 X 2.5 cm. and unable to determine. The PU worsened to unstageable due to presence of 90% slough. Despite the fact the wound worsened to an unstageable PU, there was lack of evidence of notifications R36's attending physician, and to R36's responsible party/ power of attorney. Findings reviewed with E1 (NHA), E2 (DON), E3, E4, E20 (ED), and E32 (RCN) on 2/12/18 at approximately 4:00 PM. Severity/Scope = 2/1	F 580		
F 641	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for one (R29) out of 34 sampled residents the facility failed to accurately assess a pressure ulcer. Findings include: 1. Cross refer F686, example #2. The following was reviewed in R29's clinical record: 12/11/17 - Wound assessment documents the presence of a stage 2 PU to the left foot. 12/26/17 - Quarterly MDS documented 1 stage 1 PU and 1 stage 2 PU. 2/9/18 around 2:00 PM - Interview with E4	F 641	A. R29 Minimum Data Set (MDS) was corrected to reflect the correct number of pressure ulcers on 2/9/18. B. Current residents with pressure ulcers will have their MDS reviewed to ensure accuracy of the documentation for pressure ulcers C. The RNAC will be educated regarding proper documentation of the MDS section M. D. An audit of 5 residents with pressure ulcers will be reviewed monthly for 3 months to ensure accurate documentation of MDS section M. All audit results will be forwards to the Quality Assurance Process Improvement team for review and recommendations.	4/2/18

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F 641	Continued From page 15 (RNAC) confirmed that R29 only had one PU and that she would make a MDS correction. Findings reviewed with E1 (NHA), E2 (DON), E3, E4, E20 (ED), and E32 (RCN) on 2/12/18 at approximately 4:00 PM. Severity/Scope = 2/1	F 641		
F 655	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of	F 655		4/2/18

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F 655	Continued From page 16 this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined, that the facility failed to have a system to ensure resident and/or their representative were provided a summary of baseline care plan for 5 (R50, R36, R312, R54 and R55) out of 34 sampled residents with an admission date on or after 11/28/2018. Findings include: 1. Review of R36's clinical record review revealed the following: 1/5/18 - R36 admitted to the facility. 1/16/18 - Baseline care plan, the interim care plan developed. Record review lacked evidence that R36's representative was provided a summary of the baseline care plan. 2/5/18 at approximately 11:29 AM with E4 (RNAC) confirmed that the facility currently did not have a system in which a summary was	F 655	A. R36 was no longer in the facility however had attended full care plan review meetings prior to survey. R50, R32, R54, and R55 had attended full care plan review meetings prior to survey. B. Resident□s admitted within the past month were given baseline care plans within 72 hours. C. Licensed Nursing staff and Registered Nurse Assessment Coordinator will be educated that new admissions and re-admissions will be given their baseline care plan within 72 hours of admission. D. An audit of 5 residents newly admitted will be completed weekly for 4 weeks and then monthly for 2 months to ensure that there is documentation that the baseline care plan was provided to the resident within 72 hours. All audit results will be forwards to the Quality Assurance Process Improvement team for review and recommendations.	

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F 655	Continued From page 17 available and provided to the resident and or the responsible party. E4 indicated that the facility will correct the issue immediately. 2. Review of R50's clinical record review revealed the following: 1/9/18 - R50 admitted to the facility. 1/10/18 - Baseline care plan, titled interim care plan was developed. Record review lacked evidence that R50's representative was provided a summary of the baseline care plan. 2/5/18 at approximately 11:29 AM - Interview with E4 confirmed the facility currently did not have a system in which a summary was available and provided to the resident and or the responsible party. 3. Review of R312's clinical record review revealed the following: 1/29/18 - R312 admitted to the facility. 1/29/18 - Baseline care plan, the interim care plan developed. Record review lacked evidence that the resident or the resident's representative was provided a summary of the baseline care plan. 2/5/18 at approximately 11:29 AM - Interview with E4 confirmed that the facility currently did not have a system in which a summary was available and provided to the resident and or the responsible party.	F 655		

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F 655	Continued From page 18 4. Review of R54's clinical record revealed the following: 1/12/18 - R54 was admitted to the facility. 1/14/18 - A baseline plan of care was developed and implemented. However, R54's clinical record lacked evidence that the baseline plan of care or a summary was provided to R54 and his representative. 2/12/18 at 10:06 AM - During an interview, E4 (RNAC) stated that she was unaware of the new requirement to provide a written copy of the baseline plan of care or a summary to the resident and the resident's representative. Finding was confirmed. 5. Review of R55's clinical record revealed the following: 12/7/17 - R55 was admitted to the facility. 12/7/17 - A baseline plan of care was developed and implemented. However, R55's clinical record lacked evidence that the baseline plan of care or a summary was provided to R55 and her representative. 2/12/18 at 10:06 AM - During an interview, E4 (RNAC) stated that she was unaware of the new requirement to provide a written copy of the baseline care plan or a summary to the resident and the resident's representative. Finding was confirmed. Findings reviewed with E1 (NHA), E2 (DON), E4, E20 (ED), and E32 (RCN) on 2/12/18 at	F 655		

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F 655	Continued From page 19 approximately 4:00 PM. Severity/Scope = 2/2	F 655		
F 656	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 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	F 656		4/2/18

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F 656	Continued From page 20 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 observation, record review and interview it was determined that for 3 (R7, R11 and R17) out of 34 sampled residents the facility failed to ensure a care plan was developed based on the comprehensive assessment. Findings include: 1. Cross refer F758, example #1 The following was reviewed in R7's clinical record: 8/22/17 - Resident admitted to facility from assisted living unit. 8/22/17 - Admission orders for Aripiprazole (Abilify) 5 mg diagnosis dementia with behavioral disturbance / dx dementia with delusions, Celexa 40 mg qd for MDD. Remeron 15 mg for MDD and Lexapro 5 mg for MDD. 8/29/17 Admission MDS - Antipsychotic and antidepressant use daily and diagnoses of anxiety and depression. 9/6/17 - Resident Care Guide did not include any references to behaviors. 9/7/17 Care plan - R7 has inappropriate behavior of yelling, resistive to care, combative, resistive to	F 656	A. R7, R11, and R17 care plans have been updated to reflect current status and interventions. B. Current resident care plans will be reviewed and updated as appropriate to reflect current conditions and interventions. C. Licensed Nursing staff and the Interdisciplinary Team will be educated on the need to update and develop care plans that accurately reflect resident status and current interventions. D. An audit of 5 residents will be completed weekly for 4 weeks and then monthly for 2 months to ensure that care plans are up to date and accurately reflect resident needs and current interventions. All audit results will be forwards to the Quality Assurance Process Improvement team for review and recommendations	

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F 656	Continued From page 21 eating related to dementia; goal - will not exhibit behaviors more than 3x a week through next review; approaches include: psych consult, maintain quiet, relaxed atmosphere to decrease confusion, calm gentle approach, explain all cares before doing, administer and monitor meds as ordered, behavior monitoring and record episodes each shift with interventions, encourage participation in appropriate activities, leave alone and reapproach later when combative / resistive. 9/7/17 Care plan - R7 requires use of psychotropic med to manage mood and/or behavior issue. Resident is on antipsychotic, and antidepressant. Dementia with hallucinations, delusions, behavior disturbance. Goal: R7 will respond cooperatively to behavior interventions resulting in maintenance on lowest therapeutic dose of medication and will not show side effects of medicaton thru next 90 days. Interventions included: monitoring of side effects and attempt / initiate gradual dos reduction as recommended by pharmacist as ordered by MD. The care plans failed to address how R7 presented with hallucinations and delusions and failed to include individualized pharmacological approaches. 9/7/17 10:11 AM - ID note for risk meeting documented: antipsychotics medication reviewed. Resident currently receives Abilify, Celexa, Lexapro and Remeron with diagnosis of unspecified dementia with behaviors and depression. Date of last gradual dose reduction was done 8/22/17. Date of last pharmacist review 7/31/17. Targeted symptoms/behaviors are aggression and depression. Symptoms/behaviors since last review have improved. Non-pharm	F 656		

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F 656	Continued From page 22 interventions include music, staff company, family visits and have been effective. IDT recommends resident needs current medication. The facility failed to personalize the care plan with approaches identified during the ID meeting. 2. Cross refer F679, example #1 The following was reviewed in R11's clinical record: R11's 8/27/17 Annual MDS and 8/29/17 Activity Assessment documented that books, newspapers, magazines and keeping up with the news was somewhat important. The Activity Assessment documented current interests of watching TV and studies bible independently, prefers to be alone. The Annual MDS indicates the resident is fully alert and oriented and dependent on staff or all activities of daily living. 9/5/17 - Care plan for activities documented R11 agreed to allow activities staff to visit once per month prior to Neighborhood Association Meeting to check to see if he would like to contribute any comments or recommendations to the meeting. The goal was R11 will continue to pursue independent leisure activities such as bird watching, watching television and reading the bible. Approaches included: assess for changes in activity pursuits. 01/31/18 9:51 AM - Observation of R11 reveals no use of his leg and arms and limited mobility of the neck. R11 verbalized he gets up to the chair a few days a week and likes to read his bible. He confirmed that he cannot turn the pages and needs staff to turn the pages for him. The	F 656		

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F 656	Continued From page 23 resident said it takes about 10 minutes for him to read the open pages. R11 revealed that when he was up on 1/30/18, no one turned the page on the Bible so he read the same pages over and over. He stated "that is the only activity I am interested in ". 2/06/18 11:00 AM - Interview with E37 (LPN) and E26 (Director of Community Life) revealed that audio and ipad Bibles have been trialed with out success. It was revealed that when R11 is up in the chair the assigned aide lets staff know he is up with his bible and staff including aides, activities and nursing will take turns turning the pages. R11's care plan was not personalized to include a plan to ensure the bible pages were changed to meet his needs. 3. Review of R17's clinical record revealed the following: 8/29/17 - Hospital record indicates R17 has a device related pressure injury resulting in permanent tissue loss and erosion of the urethra. R17's tear in urethral meatus was present on admission to facility and hospital. Although not documented anywhere until 11/13/17 in the Interdisciplinary Notes. 9/6/17 - Care Plan Problem - Potential for PU for R17. The medical related device pressure injury to the genitals is not identified. 9/14/17 - Care Plan Problem - Alteration in bladder elimination with indwelling catheter. The care plan did not addresses that R17 medical	F 656		

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F 656	Continued From page 24 related device pressure injury to the genitals. 2/8/18 at 8:37 AM - Discussion with E2 [DON] about R17's care plan for a medical device related to pressure injury and E2 asked E25 (RN) to look for documentation. E25 did bring two Interdisciplinary notes but not a care plan addressing a medical device related to pressure injury. Findings reviewed with E1 (NHA), E2 (DON), E20 (ED), and E32 (RCN) on 2/12/18 at approximately 4:00 PM. Severity/Scope = 2/1	F 656		
F 679	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview it was determined that for one (R11) out of 34 sampled residents the facility failed to develop a personalized activity plan based on the comprehensive assessment. Findings include: The following was reviewed in R11's clinical record:	F 679	A. R11 is now scheduled for 1:1 visits 2-3 times a week where someone will assist in turning his page so he may read silently to himself. WVD has also purchased an automatic page turner device that can change pages with a sip/puff device and a second bible of his preferred version so we can rebind the bible to fit he page	4/2/18

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F 679	Continued From page 25 R11's 8/27/17 Annual MDS and 8/29/17 Activity Assessment documented that books, newspapers, magazines and keeping up with the news was somewhat important. The Activity Assessment documented current interests of watching TV and studies Bible independently, prefers to be alone. The Annual MDS indicates the resident is fully alert and oriented and dependent on staff or all activities of daily living. 9/5/17 - Care plan for activities documented R11 agreed to allow activities staff to visit once per month prior to Neighborhood Association Meeting to check to see if he would like to contribute any comments or recommendations to the meeting. The goal was R11 will continue to pursue independent leisure activities such as bird watching, watching television and reading the Bible. Approaches included: assess for changes in activity pursuits. 1/31/18 9:51 AM - Observation of R11 reveals no use of his leg and arms and limited mobility of the neck. R11 verbalized he gets up to the chair a few days a week and likes to read his Bible. He confirmed that he cannot turn the pages and needs staff to turn the pages for him. The resident said it takes about 10 minutes for him to read the open pages. R11 revealed that when he was up on 1/30/18, no one turned the page on the Bible so he read the same pages over and over. He stated "that is the only activity I am interested in ". 1/31/18 2:53 PM - 3:45 PM - R11 in chair reading Bible the only page turns were done by surveyor while making periodic observations. Resident confirmed by interview that no staff had been in	F 679	turner. R11 is agreeable to plan. B. Current resident care plans will be audited to ensure that their care plans reflect their interests and preferences for activity pursuits and assistance is provided to carry it out. C. Community Life team will be educated on the need to carry out the assistance that is required for care planned activities D. An audit of 5 residents will be completed weekly for 4 weeks and monthly for 2 months to ensure resident preferences and interests are indicated on the care plan and assistance is provided to carry it out. All audit results will be forwards to the Quality Assurance Process Improvement team for review and recommendations.	

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F 679	Continued From page 26 for page changing. 2/06/18 11:00 AM - Interview with E37 (LPN) and E26 (Director of Community Life) revealed that audio and ipad Bibles have been trialed with out success. It was revealed that when R11 is up in the chair the assigned aide lets staff know he is up with his Bible and staff including aides, activities and nursing will take turns turning the pages. 2/06/18 11:47 AM - Interview with E38 (CNA) revealed R11 gets up to chair and reads his Bible, he cannot turn the page and tells me to flip to the next page. It was revealed that he usually gets up around 2:30 PM so she does not know what the next shift does with the Bible. 2/6/18 3:45 PM - Resident observed up in chair, R11 verbalized that he got up at 2:40 PM and his Bible has only had one page change. At 4:05 PM the resident had gone back to bed due to his back hurting. 2/8/18 4:30 PM - Resident observed in bed. Stated he just went back to bed, but when he was up between 4:00 and 4:20 PM, no Bible page changes were offered. Findings reviewed with E1 (NHA), E2 (DON), E20 (ED), and E32 (RCN) on 2/12/18 at approximately 4:00 PM. Severity/Scope = 2/1	F 679		
F 684	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that	F 684		4/2/18

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F 684	Continued From page 27 applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, record reviews, interviews and review of facility and other documentation, it was determined that for 3 (R55, R361, and R50) out of 34 sampled residents, the facility failed to provide treatment and care in accordance with professional standards of practice and the comprehensive person-centered care plans, resulting in harm for 2 [R55, R361] out of 3 residents. For R55, the facility failed to asses and monitor the blood sugar, for approximately 27 days, as she received insulin daily. This resulted in R55's emergent transfer and admission to the hospital for diagnosis of hypoglycemia with a blood sugar of 26. For R361, the facility failed to ensure the administration of insulin as ordered, the monitoring of FSBS, medical consultation of elevated BS resulting in two hospitalizations for DKA. For R50, after ordering a new diuretic the facility failed to follow-up with the attending physician to obtain an order for laboratory services. In addition, R50 experienced a significant change in condition including hypotension and severe weakness and the facility failed to complete a comprehensive assessment. Findings include: 1. The manufacturer's prescribing information for Levemir insulin, last revised on 3/2015, stated, "Levemir is a long-acting...insulin...Once daily administration should be given with the evening	F 684	A. R55 had blood glucose levels monitored upon re-admission with no subsequent hypoglycemic episodes and has since been discharged home. R361 was no longer a resident in the facility at the time of the survey. R50 Labs completed and physician assessed on 2/6/18 with new orders received. Repeat labs completed on 2/14/18 and within normal limits. Resident has since discharged home. B. Current residents with insulin orders have been reviewed and orders have been obtained to obtain blood sugar monitoring, orders for hypoglycemic & hyperglycemic protocol. A head to toe assessment will be completed for current residents, current orders will be reviewed for appropriateness based on assessment results, physician will be notified for any abnormal findings, and care plan updated if needed. C. Licensed Nurses will be educated regarding need for blood glucose monitoring with insulin, insulin administration associated with meals, and the hypoglycemic/hyperglycemic protocols. Licensed Nursing staff will be educated regarding physician notification for change in condition, obtaining	

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F 684	Continued From page 28 meal or at bedtime...WARNINGS AND PRECAUTIONS...Monitor blood glucose in all patients treated with insulin...Hypoglycemia is the most common adverse reaction of insulin therapy and may be life-threatening...Blood glucose monitoring is essential in all patients receiving insulin therapy...Severe hypoglycemia can lead to unconsciousness...and may result in temporary or permanent impairment of brain function or death....The timing of hypoglycemia usually reflects the time-action profile of the administered insulin formulations. Other factors such as changes in food intake (e.g. amount of food or timing of meals), exercise, and concomitant medications may also alter the risk of hypoglycemia...As with all insulins, use caution in patients with hypoglycemia unawareness and in patients who may be predisposed to hypoglycemia (...patients who fast or have erratic food intake)...DRUG INTERACTIONS...A number of medications affect glucose metabolism and may require insulin dose adjustment and particularly close monitoring. The following are examples of medications that may increase the blood glucose-lowering effect of insulins including LEVEMIR and, therefore, increase the susceptibility to hypoglycemia: oral antidiabetic medications...After subcutaneous injection of LEVEMIR in...patients with diabetes, insulin...concentrations had a relatively constant concentration/time profile over 24 hours with the maximum...concentration...reached between 6-8 hours post[after]-dose...". Review of R55's clinical record revealed the following: 12/7/17 - R55 was admitted to the facility for short-term rehabilitation with diagnoses that	F 684	physician orders timely, and initiating appropriate interventions for abnormal assessment/observation results. D. An audit of 5 residents on insulin will be completed weekly for 4 weeks and then monthly for 2 months to ensure that appropriate blood glucose monitoring and hypoglycemic/hyperglycemic protocols are in place. An audit of 5 residents will be completed weekly for 4 weeks and then monthly for 2 months to ensure that there has been appropriate physician notification, follow-up, and interventions based on abnormal assessment/observation findings. An audit of 5 residents will be completed weekly for 4 weeks and then monthly for 2 months to ensure ordered laboratory tests were completed. All audit results will be forwards to the Quality Assurance Process Improvement team for review and recommendations.	

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F 684	Continued From page 29 included Diabetes. 12/9/17 - R55 was care planned for Diabetes which stated, "needs monitored for hyper/hypo-glycemic reactions". R55's care plan goal stated, "will maintain accu-check and FBS of 60-300 unless otherwise ordered by MD x 90 days". The care plan interventions included, but not limited to: "Medications as ordered; monitor for s/s of hypoglycemia...; ...Monitor blood glucose levels thru capillary checks per MD order- See POS for monitoring frequency, rotate draw site. Notify MD if beyond ordered parameters; Monitor labs as ordered...Report abnormal results to MD for follow up orders; Monitor and record daily meal intakes. Report changes in appetite, notify MD as indicated; Offer HS nourishment per recommendations of RD/LDN or MD. Record intakes and note inconsistencies in intake and acceptance." 12/12/17 - Review of the POS included the following ordered medications for R55's diagnosis of Diabetes: - Levemir insulin - inject 36 units subcutaneously at bedtime (8:01 PM); - Glipizide 10 mg tablet - take 1 tablet orally BID (9:01 AM and 5:01 PM); and - Metformin 1,000 mg tablet - take 1 tablet orally BID with meals (9:01 AM and 5:01 PM). Further review of R55's POS revealed the absence of a physician's order for accuchecks. The facility failed to order accuchecks for R55, a diabetic who received insulin daily. 12/14/17 - R55's BMP and HgbA1C lab results, which were drawn at 6:53 AM, revealed: - fasting Glucose was low at 66 - normal range 70 to 140;	F 684		

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F 684	Continued From page 30 - HgbA1C was high at 7.1 - normal range 4.0 to 6.0. 12/14/17 at 8:40 PM - A nurse's note stated that she called E35 (on call physician for E8, physician) with R55's lab results and was told to fax the lab results to E8's office. 12/14/17 at 9:08 PM - A faxed transmission verification report revealed that the labs were faxed to E8. There was no evidence in R55's clinical record as to the physician follow-up response to her abnormal labs. 12/29/17 - The pharmacist's monthly medication review of R55's clinical record failed to identify that accuchecks were not being performed on a diabetic resident who received insulin daily. 1/1/18 to 1/3/18 - Review of R55's meal intakes revealed the following: - 1/1/18 - 100% meal intakes for breakfast, lunch and dinner; - 1/2/18 - no recorded meal intakes for breakfast and lunch. 50% meal intake for dinner; and - 1/3/18 - no recorded meal intakes for breakfast and lunch. 100% meal intake for dinner. Review of R55's clinical record lacked evidence of snack consumption from 1/1/18 through 1/4/18. 1/4/18 at 7:47 AM - A nurse's note stated, "Resident found unresponsive approx. 5:50 AM, breathing normally, foamy sputum around the mouth, skin pale and clammy, no response to verbal/painful stimuli Vital Signs> 96.3 (temperature), 140/77 (blood pressure), 118	F 684		

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F 684	Continued From page 31 (heart rate), 96% (pulse ox) on room air. resident noted FULL code and diabetic. blood sugar reading 26. Glucagon injection administered at 6:05 AM and 911 services activated...(fasting blood sugar) at 5 min post glucagon 31, and 71 (at) 10 min post [after] glucagon. EMS arrived at this time...". 1/4/18 - R55 was emergently transferred via 911 and admitted to the hospital. 1/5/18 at 8:52 PM - The hospital record stated, "...presented to the ED with hypoglycemia...EMS documented BS 26...subsequently patient received glucagon IM and her FS improved then dropped again and she had to be placed on D5 (intravenous solution). Reviewing her medication we noticed that patient is on long acting insulin Levemir (36 units)...glipizide (10 mg) BID and metformin...Continue metformin 1,000 bid, Levemir 10 units, and hold glipizide...". 2/7/18 at 1:52 PM - During an interview, E17 (RN Supervisor) confirmed that R55's blood sugar should have been checked as she was on 36 units of insulin daily. 2/9/18 at 10:12 AM - During an interview, E8 (physician) confirmed that accuchecks were not ordered from R55's admission date of 12/7/17 until she was readmitted from the hospital on 1/6/18 status post hospitalization for hypoglycemia. E8 stated that R55 should have had accuchecks when on an insulin. 2/12/18 at 4 PM - Findings were reviewed during the exit conference with E1 (NHA) and E2 (DON). The facility failed to monitor R55's blood sugar as she received insulin daily, which resulted in R55's	F 684		

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F 684	Continued From page 32 emergent transfer and admission to the hospital for diagnosis of hypoglycemia with a blood sugar of 26. 2. The American Diabetes Associations "Standard of Medical Care in Diabetes - 2018" states that medical providers in long term care facilities should be called as soon as possible if a resident's glucose values greater are than 250 mg/dL within a 24 hour period (Source: Diabetes Care 2018 Jan; 41 Supplement 1: S119-S125.) Cross refer F760, example #1. The following was reviewed in R361's clinical record: R361 was admitted to the facility on 10/31/17 at 5:30 PM with diagnoses which included diabetes (DM), CHF, altered mental status, COPD, history of kidney transplant, recent UTI with sepsis, and lung cancer. 10/31/17 6:53 PM - ID note - Resident admitted from (hospital name) at 5:30 PM....alert and oriented x2 with periods of confusion. Review of body system done and medications verified with the primary care physician. 10/31/17 - Admission orders included but were not limited to: Humalog insulin at meal times; 10u at breakfast, 16u at lunch and 18u at dinner For DM; Lantus insulin 52u at bedtime for DM; Carvedilol 12.5 mg AM and evening for heart failure; Cipro daily in morning for infection; Cyclosporine 25 mg take 2 morning and evening for anti rejection/kidney transplant; Lasix 80 mg morning and evening for heart failure; Potassium 20 meq take two morning and evening for low potassium. There was no order for the frequency of FSBS, any parameters	F 684		

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F 684	Continued From page 33 for blood sugar readings and no sliding scale insulin orders to cover elevated blood sugars. 10/31/17 - MAR documented the following medications were not administered "pending pharmacy delivery"; Lantus, Carvedilol, Zyrtec, Cipro, Cyclosporine, Lasix, and Potassium. The Humalog was not on the October MAR to administer with dinner even though the resident arrived at dinner time. Review of the Omnicell and E-kit [stock medications] content lists revealed the Lantus, Carvedilol, Cipro, and Potassium were all available on the unit. Review of MAR and POS lacked evidence that a FSBS was done on 10/31/17 (dinner and bedtime, as indicated on MAR with ordered insulin) after admission to the facility. The MAR listed the Lantus to be administered at 9:00 PM but documented it was not administered because it had not arrived from the pharmacy. 11/1/17 - MAR documented the FSBS at breakfast - 489, lunch - 435, dinner 489 and bedtime 491. There was no evidence that the elevated BS was addressed or that the MD was contacted. 11/2/17 3:01 AM - ID note documented vital signs WNL. 11/2/17 10:08 AM - ID note documented: "This nurse informed by the CN that the resident's blood glucose check is reading high with ketones went to assess resident, resident diaphoretic with chills bedding soaked from sweat, he had received 10 units of insulin rechecked blood	F 684		

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F 684	Continued From page 34 glucose level still reading high with ketones..." 11/2/17 10:16 AM - ID note documented: Upon assessing this patient he appeared to be clammy and had vomited. Patient [pt]. finger stick read "Hi" ketones on the glucometer, pt was given 10 units of Humalog as ordered. This did not lower his glucose after being checked again...E9 (MD) was then called and ordered to send the pt. to (hospital name)... 11/2/17 11:17 AM - ID note documented; Received call from (lab name) at around 10 AM in the process of getting ready to send resident to the hospital that the glucose (from morning laboratory work) was 700... At the time of re-admission to the hospital the facility had not obtained the Cyclosporine. R361 missed 4 doses. 11/13/17 2:35 PM - Resident re-admitted to facility from hospital. Admitting diagnoses included DKA without coma and fever. Re-admission orders included: Humalog 10u breakfast, 16u lunch and 18u dinner and Lantus 45u at bedtime. No FSBS schedule or parameters were ordered. There were no hypo or hyperglycemia parameters ordered. 11/13/17 dinner BS 346 11/14/17 breakfast BS 305 11/14/17 lunch BS 297 11/14/17 dinner BS 470; no physician consult noted.	F 684		

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F 684	Continued From page 35 11/14/17 bedtime BS "Hi" 11/14/17 10:05 PM - ID note resident blood sugar reading high on the glucometer, E9 was called and notified about the high blood sugar. An order was given Humalog 10u x 1 dose and to give Humalog 5 u after lunch (sic, should have been breakfast), Humalog 10 units after lunch and Humalog 10 units after dinner. Resident had no symptoms. Continue to monitor. Although the EMR noted a physician order for the verbal Humalog order it was not carried over to the MAR. 11/15/17 MAR stated 8:01 AM BS 431 order for 10 units at breakfast, inject 16 units (unclear why this was at end of order without a designated time). The nurse documented giving 10 u. No evidence MD was contacted about elevated BS. There was no evidence the additional 5u were administered after breakfast as referenced 11/14/17 at 10:05 PM. 11/15/17 10:21 AM - ID note stated that resident at MD appointment. 11/15/17 11:35 AM - ID note office called and informed nurse that resident who had an appointment in the office this AM was being sent to (hospital name) ER per cardiologist reading elevated FSBS in the 400's and abnormal EKG... 8:32 PM ID note pt returned from (name of hospital) to facility at approx. 6:00 PM with diagnosis of hyperglycemia and altered mental status. Writer called and verified Humalog orders with E9. The facility sent the resident to an appointment with an elevated BS without consulting the	F 684		

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F 684	Continued From page 36 primary physician. 11/15/17 Sliding Scale Humalog insulin orders: 120-150 2 u 151-200 4 u 201-250 6 u 251-300 8 u 301-350 10 u 350-400 12 u > 400 14 u and call MD 11/15/17 9:01 PM - MAR documents FSBS 494 and MD ordered a one time order of Lantus 20 u, the Lantus 45 u was discontinued by the MD. It was unclear why the Lantus was discontinued. 11/16/17 3:37 AM - ID note Resident FSBS noted with a reading of High x2. Previous check at HS 494 and had received one time dose 20 u of Lantus per MD. MD notified of current high reading and given orders to send resident to ER for further evaluation....EMR arrived 0335 [3:35 AM]. 11/16/17 8:53 AM - ID note - ...admitted with DKA. 11/20/17 7:31 PM - ID note pt admitted to facility at 2:35 PM from (hospital name)...all meds verified with E9. 11/21/17 11:28 PM - ID note the patient received new insulin orders per endocrinology specialist dated 11/21/17...this included to call the specialist if BS >450. 11/27/17 2:59 AM - ID note at 12 AM this CN was notified by the RN supervisor that the patient was found on the floor. The CN arrived to the patient's	F 684		

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F 684	Continued From page 37 room and found the patient on the floor...the patient stated "I want to go to the bathroom to shower". There was no mention of the BS in this note. 11/27/17 8:45 AM - ID note the patient had two episodes of vomiting this shift, and continues to have signs and symptoms of hyperglycemia with increasing blood sugars throughout the shift @ 12:00 AM BS 499, @ 2:00 AM BS 474, @ 4:00 AM BS 434, @ 6:00 AM BS "HI" ketones. MD called and gave new orders to send the patient to ED for further evaluation. 11/27/17 8:45 AM - ID note resident transported via stretcher to (hospital name) at 8:45 AM per E9. It was not clear why there was a gap between a high BS with ketones at 6:00 AM and transport to the hospital at 8:45 AM 11/28/17 9:27 AM - ID note ...resident admitted to ICU with DKA. 2/08/18 2:27 PM - Interview with E36 (LPN) revealed that the list of medications available on the unit were on the side of the medication storage unit, the list included a bottle of Lantus insulin. E36 stated that at all nurses have access to these medications. 2/08/18 2:51 PM - Interview with E2 (DON) revealed that she did not remember this resident and would have to review the chart. 2/09/18 09:56 AM - Interview with E5 (RN) and E4 (RNAC) revealed that nurses should get medications from the Omnicell when they have not been delivered from the pharmacy. It was also revealed that if a FSBS is >400 the MD	F 684		

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F 684	Continued From page 38 should be consulted and the doctor usually has a sliding scale insulin order on the residents record. 2/09/18 10:38 AM - Interview with E7 (LPN) stated on 11/2/17 the lab had been in around 7:30 AM to draw R361's blood and it would have been around 8:30 - 9:00 AM when she got to the resident to do the morning BS and insulin. She stated that the resident was diaphoretic and clammy when she was doing her morning rounds. The doctor was called and the resident was to go to the ED. Around the same time the lab called with a critically high BS reading of 700. When asked at what FSBS would s/he contact the MD, E7 stated it depends on their individual scale but round 380 to 400. E7 was asked to check the MAR for a scale and it was revealed that there was no scale for the resident 10/31 - 11/2/17. 2/09/18 11:34 AM - Interview with E9 [MD] revealed that she did not remember this resident but generally he would expect a call for FSBS >400 and <60 and if the reading is 400 - 450 a change in insulin may be made with a reassessment the next day. When asked about the Lantus not being administered E9 stated that he should have been consulted, usually the facility calls him. 2/09/18 12:08 PM - Interview with E6 (LPN) revealed she remembers R361 being up, talking and oriented on 11/1/17 into 11/2/17 because she worked 3 - 11 PM and stayed over into the next shift. The note she wrote at 3:00 AM was just vital signs and no FSBS was done. On 11/27/17 an SBAR was written for the fall. E6 added that the resident's wife told her that the resident fell a lot around that same time at night because he did not like to be wet after an incontinence episode	F 684		

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F 684	Continued From page 39 and would try to go get cleaned up. After review of the ID note of FSBS readings, E6 stated that she would have called the supervisor and there should have been follow-up with the MD. The sliding scale from the endocrinologist was reviewed but is was unclear if she knew it was part of his treatment record. 2/09/18 3:00 PM - Interview with E3 (ADON) about 11/14/17 order associated with 10 PM ID note confirmed that it was confusing and that the order was on the POS but not on the MAR. 2/09/18 4:21 PM - Interview with E1 (NHA), E2, E20 (Executive Director), and E32 (Corporate nurse) revealed that the facility had no formal hyperglycemia protocol or policy. It was revealed that the physicians usually write their own parameters for insulin and contacting the physician for high and low BS. The above findings were reviewed and no further information was provided. The facility offered no further information on the concerns expressed on 2/11/18 prior to exit. The facility failed to ensure R361 received ordered insulin on the day of admission and failed to intervene when FSBS were over 400. This resulted in hospitalization on 11/2/17 for DKA. The facility continued to fail to identify and intervene for FSBS over 400 resulting in an ED visit on 11/15/17 for hyperglycemia and a hospitalization on 11/27/17 again for DKA. 3. Review of R50's clinical records revealed: 1/9/18 - Admitted to the facility from the hospital following treatment for dehydration and urinary tract infection.	F 684		

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F 684	Continued From page 40 1/9/18 - An admission order included a medication to treat high blood pressure and to hold the medication if systolic BP was less than 100 or heart rate was less than 50. 1/10/18 through 1/31/18 - Medication Administration Record (MAR) documented, the medication was administered daily, as ordered and did not require the medication to be held due to his SBP was greater than 100 or heart rate was 50 or less. 1/11/18 - Laboratory blood test results revealed, R50's potassium level was 4.0, within the normal range of 3.5-5.1. 1/17/18 - A physician's order to start diuretic, Lasix 40 mg. daily for swelling of bilateral lower extremities. 1/18/18 and timed 12:48 PM - IDT Note by E5 (LPN), "will follow-up with MD to get new labs BMP." Record review lacked evidence of a follow-up for an order for BMP. (Furosemide or Lasix increase urination and may lead to dehydration. While using this medicine, you may need frequent blood tests. .https://www.drugs.com/furosemide.html). 1/31/18 - MAR documented that the medication was held due to BP of 99/59. Record review lacked evidence, that the facility staff recognized the change in condition, as evidenced by hypotension of BP of 99/59. In addition, failed to identify the need to conduct a comprehensive clinical assessment and failed to	F 684		

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F 684	Continued From page 41 identify the need for a repeat BP. (Normal blood pressure in adults is lower than 120/80 mmHg. Hypotension is blood pressure that's lower than 90/60..." https://www.nhlbi.nih.gov.). 2/1/18 at approximately 10:05 AM - Surveyor was present when E5 (LPN) entered room to obtain R50's BP utilizing a wrist BP machine. R50 was sitting up in bed when reading of 90/45 was obtained and E5 asked, "How are you feeling?" and R50 replied that he was feeling dizzy. 2/1/18 - MAR documented that the medication was held due to BP of 90/45. Again, record review lack evidence that the facility recognized that BP of 90/45 was hypotension, failed to identify the need to conduct a comprehensive clinical assessment, and failed to identify the need to obtain a repeat BP. 2/2/18 and timed 5:40 AM -IDT Note by E10 (RN Supervisor) documented R50 requested to be seen by E9. R50 states that he feels like he was getting weaker. 2/2/18 and timed 6:17 AM - A fax documentation, completed by E10, faxed to E9's office, stated that that R50 stated he is getting weaker, not eating or drinking much and he states he can hardly move his arms. 2/2/18 at 9:11 AM - MAR documented further descending BP of that the medication was held due to BP of 88/46 by E5. Despite the fact R50 had three days of descending BP, increasing weakness, record review lacked evidence that the facility	F 684		

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F 684	Continued From page 42 recognized and identified this as a significant change in condition, including the fact that the weakness may be related to low potassium). (Mild hypokalemia (serum potassium 3 to 3.5 mEq/L) rarely causes symptoms. Serum potassium < 3 mEq/L generally causes muscle weakness and may lead to paralysis and respiratory failure. http://www.merckmanuals.com/professional/endocrine-and-metabolic-disorders/electrolyte-disorders/hypokalemia) 2/5/18 at approximately 10:00 AM - Surveyor interviewed E17 (RN Supervisor) who reportedly contacted E9's office earlier on 2/5/18. Surveyor inquired what information was communicated to E9 and E17 verbalized that she read E10's IDT Note timed 5:40 AM. E17 verbalized that she did not review the fax documentation in which R50 verbalized that he could barely lift up his arms due to weakness. E17 proceeded to communicate this information to E9's shortly after this interview and obtained an order for BMP. 2/6/18 - BMP indicated potassium low at 2.9. 2/6/18 and timed 8:15 PM - Potassium supplement 40 meq. by mouth one dose and 10 meq. daily, repeat BMP in one week. 2/7/18 at approximately 3:00 PM - An interview was conducted with E5. Surveyor inquired when she had to hold the medication to treat high blood pressure due to R50's low BP, whether E5 had taken a repeat on 2/1/18 and/or 2/2/18. E5 verbalized she thought she did but did not recall the reading or where this would have been documented. In addition, confirmed no repeat BP was documented in the MAR or in the IDT notes	F 684		

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F 684	Continued From page 43 for these dates. 2/9/18 at approximately 2:45 PM - An interview with the facility's Medical Director, E8 was conducted. E8 related, upon reviewing R50's initial History and Physical dated 1/10/18, E8 verbalized that BMP should have been ordered to be completed 1-2 weeks after starting of the Lasix on 1/17/18. E8 related when a resident's BP was low compared to the resident's baseline, the facility must complete a repeat BP. If the BP remains low or hypotension, the staff must conduct a complete comprehensive clinical assessment and report this to the attending physician. Additionally, E8 confirmed when R50 was complaining about weakness, a possible symptom of hypokalemia, the facility staff should have recognized the need to conduct a comprehensive clinical assessment and report accurate and complete information to E9. Findings reviewed with E1 (NHA), E2 (DON), E20 [ED] and E32 (RCN) on 2/12/18 at approximately 4:00 PM. Severity/Scope = 3/1	F 684		
F 686	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives	F 686		4/2/18

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F 686	Continued From page 44 necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record review, interviews, and review of other documentation as indicated, it was determined that the facility failed to provide the necessary treatment and services, consistent with professional standards of practice, to promote healing of a pressure ulcer for three (R36, R29, and R17) out of 34 sampled residents. For R36, the facility failed to have individualized interventions for pressure reduction resulting in PU worsening. For R29 the facility failed to conduct weekly wound assessments, failed to accurately identify tissue types and PU stages and failed to use appropriate hand washing prior to a PU treatment. For R17, the facility failed to identify a medical device related pressure injury and failed to conduct weekly assessments of the wound. Findings include: The facility's policy entitled Wound Prevention indicated that skin care will be provided in accordance with current research and practice guidelines in order to prevent breakdown from occurring. Procedure: 1. Information regarding increased risk for skin breakdown should be obtained prior to resident admission. Appropriate mattress and cushion should be obtained and ready prior to resident arrival. 2. Resident beds are equipped with pressure reducing mattresses. 3. Upon admission, Braden Scale will be completed weekly for one month to assess	F 686	A. R 36 is no longer a resident in the facility. R29 wound has been referred to the wound clinic and the wound is improving. R17 penal pressure area has healed. B. Current residents with wounds will be audited to ensure that weekly assessments were completed for the past 4 weeks and that staging/treatment is appropriate for the wound description. Also that appropriate interventions are in place and documented. C. Licensed Nurse will be educated on obtaining Braden Scale, proper wound assessment on admission and weekly, staging, treatments, interventions, and need for weekly rounds and physician notification for wound/treatment changes. A review of proper hand washing with dressing changes will also be completed. Nursing Assistants will be educated on interventions for wound prevention and proper documentation of preventative measures such as turning and repositioning. D. An audit of 5 residents will be completed weekly for 4 weeks and then monthly for 2 months to ensure that there has been weekly wound rounds, wounds staged appropriately, appropriate treatment, and documentation of preventative measures. All audit results will be forwards to the Quality Assurance	

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F 686	Continued From page 45 changing risk for skin breakdown. 4. Each resident will have a plan of care initiated addressing prevention regardless of Braden Score. Suggested interventions: Minimal risk 15-18: Monitor for clinical changes, protect skin with moisturizers, protect elbow and heels, lift resident when necessary, do not slide; apply skin barrier when needed; bowel and bladder program if needed. Moderate 13-14: Interventions from minimal risk; establish turn and reposition schedule if resident unable to self position; elevate heels from bed; dietary consult to ensure adequate calories, protein, vitamins, minerals and supplements. The facility's Wound Care Policy created 2/13/14 and last approved 11/9/16 indicates wounds will be measured and documented weekly in the EHR. The policy did not use/define the term granulation tissue. The policy did not indicate the use of skin prep on stage 2 PU that were not intact blisters. 1. Review of R36's clinical record revealed: 1/5/18 - Admitted to the facility with diagnoses including congestive heart failure and other diagnosis. 1/5/18 - Admission orders for PU, which included cleansing wound with normal saline, pat dry, apply skin prep and apply Allevyn dressing every 5 days and as needed. 1/5/18 - Initial Nursing Assessment documented that R36 was admitted with one, stage II PU of	F 686	Process Improvement team for review and recommendations.	

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F 686	Continued From page 46 the sacrum. 1/5/18 - Braden score was incomplete, thus, no score available to assess level of risk. 1/5/18 and timed 8:28 PM - Wound Rounds documentation, stated R36 was admitted with one, stage II PU of the coccyx measuring 1.0 cm. X 1 cm. X less than 0.1 cm., with no pain. 1/6/18 - Initial Physical Therapy evaluation documented that R36 required minimal assistance of staff to roll from side to side 1/6/18 - An interim plan of care documented presence of one, stage II sacral PU and in addition, R36 had potential for further development of PUs related to decreased mobility, incontinence. Goal was that the wound would heal and no further PU development in 90 days. Intervention included: - Treatment as ordered. Monitor wound weekly. Notify MD if treatment not effective. - T & R frequently as tolerated. - Encourage 100 % meal and supplement consumption. - Pressure relieving mattress. - Pressure relieving chair cushion. - Float heels when in bed. - Toilet per schedule. - Weekly skin assessment by license nurse. Although the facility identified the need for T & R, the facility failed to have a system to identify the specific frequency for T & R to be performed by the staff for a resident who was assessed as requiring extensive assistance of two staff for bed mobility. In addition, the facility utilized the term, "pressure relieving" , which is no longer being	F 686		

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F 686	Continued From page 47 utilized to describe classes of support surfaces and the term, "pressure redistribution" supersede the use of this term (National Pressure Ulcer Advisory Panel, Support Surface Standard Initiative, Terms and Definitions Related to Support Surfaces, 1/29/07) 1/8/18 - The Braden score of 14 showed R36 to be moderate risk. Although this was the initial Braden score, record review lacked evidence that staff established a T & R schedule, per "facility policy, for R36 who was not able to self position. 1/12/18 - The admission MDS assessment indicated that R36 was severely cognitively impaired for decision making, required extensive assistance of two staff persons for bed mobility, transfer, toileting and was incontinent of urine. The resident had one, stage II PU and was at risk for developing additional PU. Treatments included pressure reducing devices for chair and bed in addition to T & R program. 1/12/18 - An order for the nutritional supplement, Med Pass 2.0 to receive 120 mls at 9:00 AM and document the mls consumed. 1/14/18 and timed 9:20 AM - Wound Rounds documentation stated coccyx PU measuring 2.0 cm. X 1.4 cm. X less than 0.1 cm., with no pain. R36 was receiving nutritional supplement and Vitamin C. Plan was to assess the PU weekly by the Interdisciplinary Team for wounds, therapy for seating and positioning, and dietician for supplemental assistance. Current treatment to continue which included to clean the wound, apply skin prep and Allevyn every 5 days and PRN.	F 686		

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F 686	Continued From page 48 This wound assessment was 9 days after the initial assessment instead of weekly, per "facility policy." 1/14/18-1/23/18 - The following interventions were included on the Daily Charting Report, a documentation in which facility staff, primarily CNAs, would document the completion of care and services provided, including following skin prevention measures: - Pressure reducing cushion to chair. - Pressure reducing mattress. - Skin prevention measures, cream applied. - T & R frequently as tolerated. - Offload heels. For all the above interventions, there was lack of consistency in applying interventions as noted in the following documentation: 1/14/18 - Night shift, E16 (CNA) documented "not applicable" at 2:51 AM. 1/15/18 - Night shift, E16 documented "not applicable" at 5:59 AM. 1/16/18 - Evening shift, no documentation. 1/16/18- Night shift, E16 documented "not applicable" at 12:56 AM. 1/17/18 - Evening shift, no documentation. 1/18/18 - Night shift, E16 documented "not applicable" at 4:28 AM. 1/19/18 - Evening and night shifts, no documentation. 1/19/18- Night shift, E16 documented "not applicable" at 5:57 AM. 1/20/18 - Night shift, E16 documented "not applicable" at 1:14 AM. 1/21/18 - Night shift, E15 (CNA) documented "not applicable" at 2:29 AM. 1/22/18 - Day shift, E30 (CNA) documented "not applicable" at 12:09 PM. Evening shift, no	F 686		

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F 686	Continued From page 49 documentation. 1/15/18 - The Braden score remained unchanged at 14. 1/17/18 - The Braden score changed to 13 from 14, due to change in R36's ability to change and control body position from slightly limited to very limited (R36 makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently). Record review lacked evidence of reassessment of the interventions based on the Braden score change. 1/22/18 - The Braden score documented 16, placing R36 at minimal risk. 1/22/18 and timed 10:52 PM - Progress note by E6 (LPN), documented R36 was sitting in her wheelchair most of the shift, repositioned every 2 hours and taken to her room at 8:15 PM. R36 appeared lethargic and required 2 staff assist to be transferred from wheelchair to bed. 1/22/18 - OT Daily Treatment Note, by E13 (Rehab Department Director) documented that ROHO cushion to replace regular cushion as patient has a stage 2 to buttocks. 1/23/18 and timed 7:11 PM - Wound Rounds documentation stated coccyx PU measuring 2.2 cm. X 2.5 cm. and unable to determine. The PU worsened to unstageable due to 90% slough. New intervention included to offload (buttocks) after meals and treatment changed to Santyl [medicated treatment].	F 686		

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F 686	Continued From page 50 Record review revealed comprehensive assessment of the PU was conducted during the facility's scheduled Wound Rounds on 1/23/18. Thus, the comprehensive assessment of PU was conducted on the 9th day rather than weekly. Despite the fact the wound worsened to an unstageable PU, there was lack of evidence that R36's attending physician was notified. In addition, there was no evidence that the Registered Dietician or R36's authorized representative were notified of the change in condition. 1/23/18 - A care plan for unstageable coccyx wound was implemented, with new interventions which included to offload buttocks after meals, ROHO cushion, and air mattress. 1/24/18 and timed 10:44 AM - IDT Note by E13 (RDD) documented wound rounds were completed on 1/23/18. Occupational Therapy changed out R36's cushion on 1/22/18 to a ROHO to increase skin integrity and Therapy will continue to monitor. 2/9/18 at approximately 2:45 PM - An interview with E4 (RNAC) and E3 (ADON) revealed that the T & R frequently as tolerated should be completed during CNA rounds every two hours. They confirmed, however, confirmed that there was no specific time to perform this intervention. 2/9/18 at approximately 3:00 PM - An interview with E14 (CNA) revealed that if a resident had an intervention to T & R frequently as tolerated, E14 would perform this task every 2 hours and document in the facility's EMR system, Point of Care (POC).	F 686		

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F 686	Continued From page 51 2/9/18 at approximately 3:10 PM - An interview with E15 (CNA) revealed for a resident, with an intervention to T & R frequently as tolerated, E15 would perform this task every 2 hours and document in the facility's EMR system, POC. 2/9/18 at approximately 3:15 PM - An interview with E6 (LPN) revealed that oftentimes, during evening shift, rooms 501, 502, 503, and 504 had CNA assigned. For the remainder of the rooms, however, licensed nurses were expected to perform primary care nursing (all care and services) for the residents. While E6 does have access to the POC in the EMR system, E6 does not document in the system but instead documents in the IDT notes. E6 related for an intervention to T & R frequently as tolerated, she would complete this intervention every two hours and document in the IDT Notes and not in the POC system. [R36 resided in a room where primary care was given.] 2/10/18 at approximately 7:45 AM - An interview E11 (Night RN Supervisor) revealed, she monitored the provision of care and services by the staff, including CNAs throughout the shift and also reviews the CNA documentation around 3:00 AM as well as toward the end of the shift to ensure documentation of the interventions are completed. E11 related, for a resident care planned for T & R frequently as tolerated, E11's interpretation of frequently would be 2-3 hours as tolerated. 2/12/18 at approximately 10:09 AM - An interview with E16 (CNA) revealed that although E16 would attempt to T & R R36 every two hours during rounds, R36 was able to T & R herself and even when E16 tried to T & R R36, R36 would turn	F 686		

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F 686	Continued From page 52 herself to the opposite direction. E16 reported to the surveyor, that earlier on this date, the facility's ADON, E3 contacted E16 regarding proper documentation in the facility's POC system. 2/12/18 at approximately 11:15 AM - An interview with E3 (ADON) revealed that she recalled, on 1/15/18, she verbally informed E13 (RDD) that R36 needed a consultation fro seating and positioning and to ensure R36 had "everything she needed." E3 reported the initial chair cushion, which was a gel cushion was switched to ROHO, another pressure redistribution cushion in R36's wheelchair on 1/22/18, approximately 7 days after the request. 2/12/18 at approximately 9:30 AM - An interview with E13 (RDD) revealed that, on 1/22/18, E13 was providing therapy services to R36. E13 did not like how R36 was positioned in the wheelchair, with the gel cushion and switched R36 onto a ROHO cushion on 1/22/18. 2/14/18 at approximately 9:20 AM - An interview with E34 (OT) revealed that R36's ability to to turn in bed fluctuated due to R36's condition. R36 required minimal assistance of staff to contact guard to completing the T & R. E34 recalled a discussion with E13 (RDD), regarding switching the cushion from gel to ROHO. 2/14/18 at approximately 12:35 PM - A subsequent interview with E13 (RDD) revealed that seating and positioning consult was usually made via e-mail. E13 was asked, whether she recalled a verbal request for seating and positioning consultation from E3 (ADON), related to R36 on 1/15/18. E13 verbalized she was not able to say for sure. E13 related that R36 was	F 686		

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F 686	Continued From page 53 not independent with T & R in bed and would require staff assistance. Again, E13 related that she switched the cushion to a ROHO since she did not like how R36 was positioned while E13 was providing treatment in the Therapy Department. The facility failed to: - Determine an individualized T & R schedule on 1/5/18 for a resident who required assistance with bed mobility. - Ensure the T & R interventions were being consistently completed. - Reassess interventions when R36's Braden score documented a change in her ability to change and control body position. These failures resulted in worsening of stage II PU to unstageable. 2. The following was reviewed in R29's clinical record: 12/7/17 6:50 PM - ID note - ...scabbed area to left outer aspect of great toe. There is a flap of skin present that is dry however 100% granulation of the area noted. Measuring 0.8 cm x 1 cm there is no drainage and the wound is dry. Skin prep applied. Granulation tissue not a tissue type of stage 2 PU (Stage 2 Pressure Injury "Granulation tissue, slough and eschar are not present" http://www.npuap.org/national-pressure-ulcer-advisory-panel) 12/8/17 - Care plan (R29) has a unstageable PU to left outer foot proximal (near center) to left great toe, hard dark area of breakdown surrounding. Approaches included: no shoe left foot; treatment as ordered, ...monitor and	F 686		

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F 686	Continued From page 54 measure wound weekly; elevate feet and heels in bed. 12/11/17 - Wound assessment - type pressure, left foot, 0.8 cm x 1 cm x 0; stage 2; granulation; cleanse area with NSS apply skin prep q shift; open area to left outer foot proximal to great toe. The facility again incorrectly identified the wound as stage 2 with granulation tissue. There was no weekly assessment 12/19/17. 12/26/17 - Quarterly MDS documented the presence of 1 stage 1 PU and 1 stage 2 PU, highest tissue type granulation. 12/29/17 - Wound assessment documented 1 cm x 0.7 cm x 0; granulation tissue; residents left lateral great toe re-evaluated this tour...hard black scab ...treatment of skin prep continues. The facility describes both granulation tissue and a hard dark scab which are not the same tissue types. No weekly wound assessment found for first week of January 2018. 1/12/18 2:19 PM - ID note - assessment of area to left lateral great toe 2 x 2 circular area is dark brown, hard, with no drainage, tender to touch, skin prep as ordered q shift. 1/14/18 - Wound assessment 1.5 cm x 1.5 cm x uta; necrotic/eschar; unstageable; without shoe to foot. No wound assessment for 10 days. 1/24/18 - Wound assessment 2.5 cm x 2.5 cm x	F 686		

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F 686	Continued From page 55 uta; tissue type eschar. 1/31/18 - Wound assessment 2.2 cm x 2.4 cm x uta eschared area to the lateral great toe. 2/5/18 2:02 PM - Observation of the left toe PU revealed that after setting up supplies E37 (LPN) washed hands, touched the door and light switches and changed gloves without washing hands again before starting the treatment. 2/6/18 - Wound assessment 2.2 cm x 1 cm x uta open area to the left great toe with yellow "sloth" (slough). 2/7/18 (unknown time) - Interview with E3 (ADON) about missing wound assessments revealed that the surveyor had been provided what was in the clinical record and s/he was unsure if there were any other assessments. 2/8/18 around 8:30 AM - Interview with E3 provided copies of weekly skin checks but was unable to provide anymore weekly wound assessments. It was confirmed that the facility had a wound committee that reviewed resident wounds. Concerns were expressed by surveyor about errors in assessment and tissue types. 2/8/18 1:04 PM - Interview with E39 (RN, former unit manager) revealed that the use of the term "granulation tissue" may have been the wrong word, s/he described the wound as being healing tissue that was discolored but not pink but darker then the rest of the skin. The facility failed to consistently and accurately assess the PU. The facility also failed to use correct/proper infection control technique when	F 686		

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F 686	Continued From page 56 performing a dressing change. 3. Review of R17's clinical record revealed the following: 8/29/17 - Hospital record indicates R17 has a device related pressure injury resulting in permanent tissue loss and erosion of the urethra. R17's Tear in urethral meatus was present on admission to facility and hospital. Although not documented anywhere until 11/13/17 in the Interdisciplinary Notes. 9/1/17 at 1:57 PM - E2 (DON) entered an Interdisciplinary Note. R17 admitted to facility on stretcher. R17 is hospice. Skin assessment completed without mention of any irregularities or trauma to the genital region. In review of September Interdisciplinary Notes it was revealed that no assessment of a medical device related pressure injury occurred. 9/1/17 - History and Physical completed by physician without mention of any irregularities or trauma to the genital region. 9/1/17 - Skin Assessments include a bruise to the hand, bruise to the back of the left hand, callous to bilateral inner left and right heels present upon admission, pressure ulcer red non blanchable area to coccyx. The assessment does not reflect any irregularities or trauma to the genital region. 9/6/17 - Care Plan Problem - Potential for PU risk factors for R17 are decreased mobility, bowel incontinence, Parkinson's and Hospice Care. The medical related device pressure injury to the	F 686		

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F 686	Continued From page 57 genitals is not identified as a risk in the Care Plan problem statement. 9/14/17 - Care Plan Problem - Alteration in bladder elimination with indwelling catheter. The care plan does not address a medical related device pressure injury to the penis from the indwelling catheter. 10/13/17 - Hospice Comprehensive Assessment Nursing Summary did not include any information regarding irregularities or trauma to the genital region. In review of October Interdisciplinary Notes it was revealed that no assessment of a medical device related pressure injury occurred. In review of November Interdisciplinary Notes it was revealed that on 11/13/17 and 11/20/17 that no changes to the genital area were documented. (Medical device related pressure injury). 12/14/17 - A Care plan meeting notation found in the Interdisciplinary Notes states resident does not have any skin issues or concerns. 1/31/18 at 12:24 PM - Interview with the R17's spouse indicated R17 does have a small tear at the urethral meatus. During an interview with E24 (LPN) on 2/6/17 at 9:40 AM it was revealed that the catheter was used for urinary retention and required medically. E24 further revealed that Foley care is provided each shift and as needed. E24 described the urethral meatus when R17 was admitted from the hospital as being split on the underside from the tip of the penis to the scrotum.	F 686		

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F 686	Continued From page 58 2/6/18 at 12:30 PM - Observation revealed a measurement of 6.5 cm X 1.0 cm the area is wide open the urethra now begins from the base of the shaft to mid-way of scrotum and the catheter enters from that location. The mucosa is clean and the scrotum is free from swelling or redness. The leg strap is secure to allow some freedom to prevent additional strain and the adult brief is secure. R17 was cooperative with the exam and cleansing no signs of pain and he did not resist or become combative. 2/7/18 at 8:00 AM - During an interview with a WC1 (Wound Continence Nurse) from the transferring facility confirmed that the trauma to the urethral meatus was considered a device related pressure injury resulting permanent tissue loss and erosion of the urethral. The facility failed to identify a pressure injury related to a medical device on admission. The facility failed to care plan and conduct ongoing assessments of the pressure injury related to a medical device. Findings reviewed with E1 (NHA), E2 (DON), E20 (ED), and E32 (RCN) on 2/12/18 at approximately 4:00 PM. Severity/Scope = 3/1	F 686		
F 689	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and	F 689		4/2/18

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F 689	Continued From page 59 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, interviews and review of facility documentation, it was determined that for 2 (R62 and R33) out of 34 sampled residents, the facility failed to ensure the resident environment remained as free as possible of accident hazards and each resident received adequate supervision to prevent accidents. For R62, the facility failed to provide adequate supervision to prevent him from falling on 8/30/17, which resulted in his emergent transfer to the ED for a head laceration requiring 12 sutures. R62 sustained harm from the 8/30/17 fall. For R33, the beauty shop failed to be free of accident hazards. Findings include: 2/18/15 - The facility's Falls Management Program stated: "Any occurrence of falls along with the interventions will be documented in the nursing notes. Any fall that involves a potential actual head injury will include follow up neurological checks ...will be documented on The Neurological Assessment Flow Sheet. When a resident sustains a fall, the assessment process will include an investigation using the Fall Investigation Analysis Sheet. Ongoing monitoring and continuous quality improvement is achieved through the At Risk Team that meets weekly to review new admissions identified as being at risk, residents having falls and residents on a fall prevention program. Individualized care plan developed includes measurable objectives and time frames. Care plan for a resident assessed	F 689	A. R62 is not longer a resident in the facility. R33 had no ill effects from the hair dryer being utilized with oxygen use. B. An audit of current residents who have had falls in the past 14 days will be reviewed to determine if there was a complete incident report, investigation completed, a Register Nurse Assessment, and a new intervention completed. An audit will be conducted for current residents with oxygen use to ensure no ill effects have occurred associated with hair drying. C. Licensed Nursing staff will be educated regarding proper incident report completion, complete investigation, intervention initiation including providing appropriate supervision as appropriate, and Registered Nurse Assessment. Care plan will reflect supervision measures required for fall prevention when appropriate. Nursing staff and beautician will be educated regarding proper distance of 12 inches or more between the heat source and the oxygen source. D. An audit of 5 residents who have fallen will be completed weekly for 4 weeks and monthly for 2 months to ensure that the incident reported is fully completed, investigation completed, appropriate intervention initiated with attention to supervision when appropriate, and Registered Nurse Assessment completed. A random audit of beautician	

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F 689	Continued From page 60 as at risk for falls will be developed at the time the risk is identified with ongoing evaluation and revisions documented. Care plan updated at the time the incident occurs includes the date of the new intervention and with measurable objectives and timeframes. Interventions will address those elements determined by the investigation as probable causal factors that contributed to the fall. Updates, reviews and revisions as indicated by the At Risk Team at the weekly meeting." 1. Review of R62's clinical record revealed the following: 6/16/16 - R62 was admitted to the facility with diagnoses that included dementia and a history of falls. 6/22/17 - R62 was care planned for a history of falls with no major injury. The interventions included: monitor the resident every shift; anticipate resident's ADL needs; orient the resident to ask for assistance when transferring; ambulate with walker and one staff assist; toilet when resident attempts to get up out of chair or bed; hourly hospitality checks; frequent toileting; team approach to monitoring the resident; ensure wheels are locked in wheelchair at all times; monitor for increase agitation/restlessness that may be an indicator for the resident needing to be toileted; and orient the resident with the rollator when ambulating. 6/16/17 - Annual MDS assessment revealed that R62 was moderately cognitively impaired and was a limited assist with support of 1 person for ambulation person. R62 had 1 fall without injury. 6/28/17 - Approach of monitor resident closely	F 689	services will be conducted weekly for 4 weeks and monthly for 2 months to ensure that hair drying is done appropriately for residents with oxygen use. All audit results will be forwards to the Quality Assurance Process Improvement team for review and recommendations.	

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F 689	Continued From page 61 and assist resident to walk with a rollator was added to the care plan. 7/21/17 at 9:59 AM - ID Note - The At Risk Team met and discussed R62's 7/20/17 fall with no injuries. The root cause determined to be unsteady gait and loss of balance. The only new intervention was to continue to encourage resident to use walker. 8/1/17 at 4:40 AM - Incident Report - Description - Resident fell while trying to walk unsupervised. R62 was trying to hit staff fell and hit the back of his head. Neurological Assessment Flow Sheet and Fall Investigation Analysis Sheet not provided with the Incident report. 8/1/17 at 6:03 AM - ID Note - R62 was sitting on the floor from a fall. A head to toe assessment was done and two hematomas were noted on the back of head. E40 (RN) called the physician. An order was given to send R62 out to be evaluated at the hospital. Neuro checks were initiated per the note. Neurological Assessment Flow Sheet was not available from the facility. 8/1/17 at 7:16 AM - ID Note - R62 fell in the TV room trying to sit in the recliner (referring to the 4:40 AM fall). 8/1/17 - Hospital record - R62 with a history of recurrent falls presented to ED as an unwitnessed fall. A CT of the head, spine, chest and abdomen as well as x-rays of elbow and knee were done. Results indicate a hematoma to the back of the head without internal bleed. Wounds noted were: abrasion to the back of the head; a left lower leg skin tear; left elbow skin tear; and abrasion to nose.	F 689		

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F 689	Continued From page 62 The fall investigation follow up notes state: R62 was attempting to ambulate without assist, fell and hit his head. He was sent to the ED. The investigation packet provided did not include interviews, Neurological Assessment Flow Sheet, the assessment process, or a Fall Investigation Analysis Sheet. The facility failed to identify conflicting information that was in the reports concerning the specifics of R62's fall. One note indicated the resident fell trying to hit staff and one note indicated he fell trying to sit in a recliner. The facility failed to monitor resident closely and assist resident to walk with a rollator. 8/3/17 at 6:50 PM - ID Note - Indicated that R62 was readmitted to the facility from hospital and placed on one to one supervision to prevent falls. 8/4/17 at 1:26 PM - ID Note - Per directive from E2 (DON) E37 (LPN) discontinued R62's one to one supervision stating resolved and family notified. The reason for discontinue was not documented in the note. 8/8/17 - Psych Nurse Practitioner increased Trazadone from 75 mg to 100 mg daily at bed time for insomnia. Trazadone is an antidepressant used for its sedating effects to help with sleep. 8/10/17 at 10:12 AM - ID Note - R62 was reviewed by the At Risk Team status post admission to hospital from a fall that occurred on 8/1/17. A root cause was not determined based on the note or the investigation packet provided	F 689		

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F 689	Continued From page 63 by the facility. Medications were reviewed at this team meeting and it was agreed that R62 was taking appropriate medications for R62's diagnosis. R62 is care planned for both pharmacological and non-pharmacological pain relief methods. The note mentions care plan interventions for repositioning frequently, pressure relieving mattress, moisturizing lotion twice daily and as needed. The Risk Team agreed that all care plans are appropriate. There was no evidence that any new interventions were considered. 8/12/17 at 5:25 PM - Incident Report - R62 fell and caught by the nurse who lowered R62 to a chair without injury. 8/12/17 at 5:59 PM - Incident Report - A second fall - Resident walking with CNA and fell hit his forehead on hand rail. R62 sustained a skin tear (2 cm x 1.0 cm) to the elbow. The investigation packet provided did not include interviews, Neurological Assessment Flow Sheet, the assessment process, or a Fall Investigation Analysis Sheet for either of the falls on 8/12/17. The facility did have an Interview Statement Form for Investigative Purposes Falls completed for an 8/12/17 fall at 7:15 PM. R62 and E42 were walking. R62 fell and hit his forehead on the side rail. R62 sustained a skin tear to left elbow. E42 statement revealed R62 was toileted at 5:30 PM and ate at 7:00 PM. E6 (LPN) statement revealed that R62 was walking with E42 and fell to the floor hitting his forehead on the hallway railing. R62 sustained a skin tear to the elbow. While the incident report documented a fall at	F 689		

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F 689	Continued From page 64 5:59 PM on 8/12/17 noting that R62 hit his forehead and suffered a skin tear, the CNA interview documents a fall at 7:15 PM on 8/12/17 with the same outcomes. 8/14/17 at 5:45 AM - Incident Report - R62 fell over his walker, onto the floor, after pulling the TV off of the TV stand. E41 (LPN) could get to him to prevent the fall. E62 suffered a pinky skin tear. The investigation packet provided did not include interviews, Neurological Assessment Flow Sheet, the assessment process, or a Fall Investigation Analysis Sheet for the fall on 8/14/17. The facility failed to follow the care plan approach to monitor the resident closely. 8/23/17 at 11:25 PM - Incident Report - Resident found lying on his back on the floor in front of his wheelchair in the TV room with an abrasion on his right elbow and skin tear on his right middle finger. There are three Interview Statements Form for Investigative Purposes each stating he was found on the floor in the TV room. The CNA took him to the bathroom at 11:10 PM and returned R62 to the TV room in his wheel chair placing him in front of the TV. The fall was unwitnessed and R62 was care planned to be closely monitored. 8/24/17 at 1:46 AM - ID Note for fall on 8/23/17 at 11:25 PM - R62 found on the floor on his back. Injuries included a right elbow abrasion (1.5 cm x 1.5 cm) and a right middle finger skin tear (1.5 cm x 0.5 cm). 8/24/17 at 3:53 AM - ID Note - for a fall on	F 689		

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F 689	Continued From page 65 8/23/17 at 11:25 PM - R62 found on floor in TV room during change of shift. He was laying on his back in front of his wheel chair. R62 sustained an abrasion (1.5 cm x 1.5 cm) and a skin tear (1.5 cm x 0.5 cm) to the right middle finger. Doctor notified. 8/24/17 - Care Plan updated to include one new approach to place resident within arm's length. 8/30/17 at 5:10 AM - ID Note - R62 was monitored all night until about 5:10 AM. R62 was found on the floor while the aide was on her way from the bathroom. R62 was found in a pool of his blood from a laceration sustained on the head. 911 was called and R62 was taken to the hospital 8/30/17 - R62 was emergently transferred to the ED and admitted to the hospital for evaluation. 8/30/17 - According to hospital record R62 with history of recurrent falls presented to ED having an unwitnessed fall in the morning. It was reported that he was found face down at the nursing home with a lot of bleeding from a cut to the fore head that requires sutures, small cut to the nose and left ring finger. The facility failed to supervise R62 at an arm's length. Furthermore, R62 was emergently transferred to the hospital and did suffer injuries requiring sutures. 8/31/17 - At Risk Team Meeting to discuss falls, behavioral symptoms and R62's post fall status. R62 is currently in the hospital. R62 has a history of falls (6 this month) and 2 of the six have resulted in an injury requiring hospitalization.	F 689		

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F 689	Continued From page 66 According to current notes from the hospital, the occurrences are "more of a recurrent problem for him secondary to ambulatory dysfunction and inability for him to be rehabilitated due to his severe dementia and behavioral issues." 9/2/17 - R62 was discharged from the hospital and returned to the facility with diagnoses that included: laceration of scalp - primary, fall, finger laceration, abrasion, and head injury. 2/8/18 at 9:06 AM - Interview with E2 (DON) - Surveyor provided a list of fall dates and requested investigations for R62's August falls. 2/9/18 at 11:20 AM - Requested fall investigations for R62's August falls from E2. 2/12/18 at 8:45 AM - Interview with E2. Requested R62's fall investigation documentation. 2/12/18 12:10 PM - Interview with E4 (RNAC) and E1 (NHA). Requested care plans with interventions, investigation notes, MAR and TAR and any additional documentation on how R62's falls were being addressed. 2/13/18, at approximately 4:00 PM, neither E1 nor E2 had provided more information on the prevention of R62's falls. R62 sustained 6 falls in August 2017. There is no evidence prior to 8/24/17 that the facility implemented new interventions after the falls. When the 8/24/17 approach for place resident at arm's length was developed, the facility failed to implement this intervention. The resident fell	F 689		

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F 689	Continued From page 67 again and sustained injuries. The facility failed to provide adequate supervision to prevent falls and injuries resulting in a hematoma on 8/1/17 and laceration with 12 sutures on 8/30/17. 2. A random observation, on 2/7/18 at 10:50 AM, R33 was observed in the beauty shop, sitting in the chair with the nasal cannula and oxygen being administered at 2 liters via portable oxygen tank. E23 (subcontracted beautician) was observed drying R33's hair using a hand held hair dryer at a distance of less than 12 inches from R33's nasal cannula. At 10:51 AM, surveyor immediately requested termination of the use of the dryer and interviewed E23 , who related that she was not aware that this was an accident hazard. At 10:55 AM, interview with E1 (NHA) revealed that the facility had no policy to address the acceptable distance from the heat source and the nasal cannula. E1 verbalized that he would develop the policy immediately. At 1:00 PM, the facility provided a copy of such policy indicating the heat source must be at least 12 inches away from the nasal cannula. Findings reviewed with E1, E2, E20 (ED), and E32 (RCN) on 2/12/18 at approximately 4:00 PM. Severity/Scope = 3/1	F 689		
F 692	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-	F 692		4/2/18

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F 692	Continued From page 68 §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, interview, and review of other facility documentation, the facility failed to ensure monitoring of weights for one (R50) of 34 sampled residents. R50, was prescribed a new diuretic and the facility failed to have a planned weight loss program which included monitoring of weights. Findings include: Policy and Procedure titled Weights, created 12/17/03 and last approved on 12/23/14, indicated objective was to ensure that all residents are weighed and that action is taken when variance occur. Residents weights are: 1. Taken on the day of admission, re-admission and weekly for four weeks thereafter. 7. Variances of plus or minus 5 #[pounds]s or more require a re-weigh within 24 hours and require report by the charge nurse to the physician, the dietician, and the responsible party. The dietician will:	F 692	A. R50 had weight/nutrition assessment on completed on 2/5/18 with physician follow-up. B. Current residents will be audited to determine if there has been significant weight loss/gain and timely re-weights with appropriate assessment, physician notification, and interventions. New admissions from February 1, 2018 through current will be reviewed to determine if admission and weekly weights have been obtained. C. Nursing staff will be re-educated regarding admission and weekly weights for 4 weeks, timely re-weights, physician notification for significant weight loss/gain, and fluid monitoring. Dietician will be educated regarding need to review weights and request interventions for weight changes. D. An audit of 5 residents will be completed weekly for 4 weeks and monthly for 2 months to ensure that	

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F 692	Continued From page 69 1. Assess the resident to determine if a significant weight change has occurred. 2. Assess the resident to determine why the change occurred. 3. Initiate approaches to remedy the change in weight. 4. Communicate the significant weight change to the RNAC. Review of R50's clinical record revealed the following: 1/9/18 - R50 was admitted to the facility with diagnoses that included urinary tract infection and dehydration. 1/9/18 - No admission weight. 1/10/18 - Initial weight of 196# 1/11/18 - Subsequent weight of 196.2#. 1/11/18 - Laboratory blood test results revealed the following values: Sodium = 137 (normal range: 135-145); BUN = 31 elevated (normal range: 9-20); Creatinine = 2.7 elevated (normal range: (0.7 - 1.3). 1/14/18 - The Admission Nutritional Assessment completed by E18 (RD), documented R50 had no swallowing disorder and the most recent weight of 196#, with an average meal intake of average intake of 80/25/50. No information of admission weight, ideal body weight or usual body weight was documented, as well as weight loss or gain history was not available within the past month or past six months.	F 692	re-weights are obtained timely, weight loss/gain is addressed by dietician with appropriate physician notification/interventions. An audit of 5 recently admitted residents will be completed monthly for 3 months to ensure admission and weekly weights were completed timely for 4 weeks. All audit results will be forwards to the Quality Assurance Process Improvement team for review and recommendations.	

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F 692	Continued From page 70 1/14/18 - A nutrition care plan documented R50 had a potential risk for altered nutritional status and/or weight loss related to diagnosis-therapeutic and mechanical altered diets. Goal included improved weight, intact skin, good fluid balance. Approaches included to provide diet as ordered, assist with set up as needed, monitor labs and weights, offer fluids at and between meals. 1/16/18 - Admission MDS assessment stated R50 was independent in daily decision making, required supervision and set up only for meals, height was 72 inches and weight was 196# and had no swallowing problems. 1/17/18 - An order for new diuretic, Lasix 40 mg. daily by mouth for swelling of [both] bilateral lower extremities. 1/19/18 - A Care Plan meeting note documented that weight was stable at 196#. Although there were no further weights after 1/11/18, the facility failed to identify the lack of weekly weigh during the Care Plan meeting. 1/22/18 - " not applicable " was documented in the EMR for weight. 1/1718 through 2/6/18 - Review of the MAR revealed R50 was administered Lasix 40 mg. on a daily basis. Although R50 was started on Lasix, record review lacked evidence of a planned weight loss program to include monitoring of weights. 1/28/18 -A hydration maintenance care plan was	F 692		

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F 692	Continued From page 71 initiated due to R50's fluid volume deficit concern related to urinary tract infection and diuretic use. The goal indicated R50 will consume all the fluids provided at meals daily and will not show signs or symptoms of dehydration for the next 90 days. Approaches included to monitor/provide intake of fluids by dietary and nursing; offer fluids between meals, keep fluids within resident reach, encourage fluids during care by nursing, monitor/assess lab/diagnostic work per order, notify MD of abnormal results by nursing; observe for signs and symptoms of dehydration such as dry, cracked lips, tenting of skin, increased confusion, decrease urinary output, ... and notify MD. 2/1/18 at approximately 9:31 AM - An interview with R50 verbalized that he does not have an appetite since he does not like the food and reported that he has lost some weight since admission. 2/1/18 - Upon surveyor's inquiry, the facility obtained weight on 2/1/18, which was 172.8 #, a variance of 23.2 # since 1/11/18 weight. Despite the fact the facility had evidence of a 23.2# weight variance, there was lack of evidence that the facility identified the need of a re-weigh to confirm the weight loss. 2/5/18 and approximately 10:00 AM - Interview with R50 revealed he still had no appetite due to due to the bland taste and wants more substantial meal since he feels he is getting weaker. 2/5/18 and approximately 12:50 PM - Interview with R50 verbalize he had a very good lunch.	F 692		

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F 692	Continued From page 72 2/5/18 at approximately 10:30 AM - An interview with E19 (RD) confirmed that E19 was not notified of the 23.2# variance from 2/1/18 weight obtained following surveyor's inquiry. E19 related that she was the new RD with employment start date of 1/23/18 and still learning the facility's system, including the EMR system and how the facility monitors meal and fluid intake, as well as monitoring of weight. 2/5/18 and timed 2:46 PM - IDT Note by E19 documented a current weight of 173.8# with 22.2# or 11.73 % weight loss noted. E19 related that the diuretic initiated on 1/17/18 might explain weight changes due to withdrawal of excess fluids. In addition, R50 reported problems with swallowing and chewing. The plan was to down grade the diet to softer consistency, speech therapy evaluation, nutritional supplement drink twice a day, weekly weight for 4 week. 2/5/18 and timed 3:02 PM - IDT Note by E17 (RN Supervisor) documented that E9 [MD] was contacted regarding weight loss and recommendation for nutritional supplement twice a day and weekly weights for 4 weeks. 2/6/18 at 9:39 AM - An interview with R50 revealed he had the best breakfast he can remember since admission to the facility. In addition, he consumed the nutritional supplement which he enjoyed. Denied weakness or dizziness. 2/6/18 - Laboratory blood test results revealed the following values indicated:: Sodium = 138 normal BUN = 41, increased from 31 Creatinine = 2.8, increased from 2.7	F 692		

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F 692	Continued From page 73 2/7/18 at approximately 5:20 PM - An interview with E3 (ADON) confirmed the following: - The facility failed to have a system to ensure weights were obtained per facility's policy. - The facility failed to have a system to ensure identification of a need for a re-weigh. This failure led to not re-weighing R50 on 2/1/18 when there was a greater than 23# variance and delayed identification of a weight loss until, upon surveyor's inquiry on 2/5/18. This resulted in delay in notification of the attending physician and E19 as well as delay in reassessment and implementation of new nutritional interventions. 2/9/18 at approximately 2:00 PM - An interview with E2 (DON) revealed it was her understanding, monitoring of weights and intake was completed by the facility's RD. 2/9/18 at approximately 3:30 PM - An interview with E3 (ADON) revealed it was her understanding, monitoring of weights and intake was completed by the facility's RD. Findings reviewed with E1 (NHA), E2 (DON), E3 (ADON), E4 (RNAC), E20 (ED), and E32 (RCN), on 2/12/18 at approximately 4:00 PM. Severity/Scope = 2/1	F 692		
F 695	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	F 695		4/2/18

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F 695	Continued From page 74 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 clinical record review, interview, and review of other facility documentation as indicated, the facility failed to ensure that a resident who needs respiratory care, based on the comprehensive person-centered care plan for one (R36) out of 34 sampled residents received the services. Findings include: Review of R36's record revealed the following: 1/9/18 - Admitted to the facility with diagnoses including chronic kidney disease, and hypertension, congestive heart failure and asthma. 1/12/18 - An order "titrate oxygen to SPo2 (oxygen saturation) to be at 92%." 1/12/18 - 1/31/18 - Medication Administration Record incorrectly transcribed the order as "oxygen/titrate patient on 2 L of oxygen/titrate keep sats > 92%." Initials of licensed nurses were documented indicating that the oxygen was applied to keep oxygen saturation greater than 92%. 1/13/18-2/1/18 Vital stats revealed R36's oxygen saturation ranged between 94% to 100%. 2/12/18 at approximately 10:15 AM - An interview with E2 (DON) confirmed that the facility failed accurately transcribe the physician's order, thus, failing to follow the physician's order for oxygen administration. This resulted in R36 receiving	F 695	A. R36 is no longer a resident at the facility. B. An audit of current residents with oxygen orders will be completed to ensure that the physician□s orders are transcribed to include clear and concise titration orders and oxygen saturation monitoring. C. Licensed Nursing staff will be educated regarding transcription of oxygen orders to include complete and concise oxygen therapy orders and oxygen saturation parameters. D. An audit of 5 residents with oxygen orders will be completed weekly for 4 weeks and monthly for 2 months to ensure that the physician orders are clear, concise, and parameters followed. All audit results will be forwards to the Quality Assurance Process Improvement team for review and recommendations.	

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F 695	Continued From page 75 continuous oxygen instead of receiving oxygen when the saturation was less than 92%. Findings reviewed with E1 (NHA), E3 (ADON), E4 (RNAC), E20 (ED), and E32 (RCN) on 2/12/18 at approximately 4:00 PM. Severity/Scope = 2/1	F 695		
F 711	Physician Visits - Review Care/Notes/Order CFR(s): 483.30(b)(1)-(3) §483.30(b) Physician Visits The physician must- §483.30(b)(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; §483.30(b)(2) Write, sign, and date progress notes at each visit; and §483.30(b)(3) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure during a physician's visit, a review the resident's total program of care was conducted, including medications and treatments, at each visit for one (R36) out of 34 sampled residents. Findings included: The following was reviewed in R36's clinical record:	F 711	A. R36 is no longer a resident at the facility B. Current residents with wounds will be reviewed to determine if the physician assessed the wound when it was identified and with a worsening in the status of the wound. C. Physicians will be educated on the need to assess wounds on admission and with worsening of a wound to determine	4/2/18

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F 711	Continued From page 76 1/5/18 - Admitted to the facility with diagnoses including hypertension, and asthma. 1/5/18 - Initial Nursing Assessment documented that R36 had a stage II PU of the sacrum. 1/8/18 - Admission History and Physical completed by R36's physician, E9. Although R36 was admitted to the facility with a pressure ulcer of the sacrum, there was a lack of evidence that E9 assessed the wound during the physical assessment on 1/8/18. 1/23/18 and timed 7:11 PM - Wound Rounds documentation stated the sacral PU worsened to an unstageable. 1/24/18 - Progress Note by E9 completed. Despite R36's PU worsened to unstageable, as documented in the above 1/23/18 Wound Rounds, the Progress Note lack evidence that E9 was aware of the PU. Findings reviewed with E1 (NHA), E2 (DON), E3 (ADON), E4 (RNAC), E20 (ED), and E32 (RCN), on 2/12/18 at approximately 4:00 PM. Severity/Scope = 2/1	F 711	appropriate treatment. D. An audit of 5 residents with wounds will be completed weekly for 4 weeks and monthly for 2 months to ensure that the physician has assessed any new wounds or worsening wounds for appropriate treatments. All audit results will be forwards to the Quality Assurance Process Improvement team for review and recommendations.	
F 756	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review	F 756		4/2/18

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F 756	Continued From page 77 of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R55) out of 34 sampled residents, the facility's pharmacist failed to identify and report any irregularities during the monthly medication regimen review. On 12/29/17, the facility's pharmacist failed to identify that	F 756	A. R55 record was reviewed and appropriate Blood sugar orders were obtained on 2/9/18. This resident has since been discharged home. B. Current residents with insulin orders will have physician orders reviewed to	

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F 756	Continued From page 78 accuchecks were not ordered for R55, who received insulin daily. Findings include: Cross refer to F684, example # 1. The manufacturer's prescribing information for Levemir insulin, last revised on 3/2015, stated, "Levemir is a long-acting...insulin...Once daily administration should be given with the evening meal or at bedtime...WARNINGS AND PRECAUTIONS...Monitor blood glucose in all patients treated with insulin...Hypoglycemia is the most common adverse reaction of insulin therapy and may be life-threatening...Blood glucose monitoring is essential in all patients receiving insulin therapy...Severe hypoglycemia can lead to unconsciousness...and may result in temporary or permanent impairment of brain function or death...". 12/7/17 - R55 was admitted to the facility for short-term rehabilitation with diagnoses that included Diabetes. 12/7/17 - R55 was ordered 36 units of Levemir insulin to be subcutaneously injected at bedtime for her diagnosis of diabetes. 12/12/17 - Review of R55's POS revealed the absence of a physician's order for accuchecks. 12/29/17 - The pharmacist's monthly medication review of R55's clinical record failed to identify that accuchecks were not ordered for a diabetic resident who received insulin daily. 2/9/18 at 10:12 AM - During an interview, E8 (physician) confirmed that accuchecks were not ordered upon R55's admission date of 12/7/17	F 756	ensure that appropriate blood sugar orders are present. C. The pharmacist and licensed nursing staff will be educated regarding appropriate blood sugar monitoring needs for residents with insulin orders. DON/designee will ensure monthly pharmacist reviews have been completed and recommendations forwarded to physician. D. An audit of residents with insulin orders will be completed to ensure proper blood sugar monitoring orders are present weekly for 4 weeks and then monthly for 2 months. A monthly audit of pharmacist reviews will be completed to ensure completed and recommendations communicated to MD's for 3 months. Audit results will be forwarded to the Quality Assurance Process Improvement team for review and recommendations.	

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F 756	Continued From page 79 until she was readmitted from the hospital on 1/6/18 status post hospitalization for hypoglycemia. 2/12/18 at 4 PM - Findings were reviewed during the exit conference with E1 (NHA) and E2 (DON). The facility's pharmacist failed to identify that accuchecks were not ordered for R55, who was receiving insulin daily on 12/29/17. Severity/Scope = 2/1	F 756		
F 758	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §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	F 758		4/2/18

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F 758	Continued From page 80 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 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 clinical record reviews, interviews and review of facility documentation, it was determined that for 3 (R7, R24 and R55) out of 34 sampled residents, the facility failed to ensure that residents who have not used psychotrophic drugs are not given these drugs unless the medication was necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use psychotrophic drugs received gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Findings include: The facility's policy Monitoring for Antipsychotics	F 758	A. R24 and R55 are no longer in the facility. R7 records have been reviewed and appropriate diagnosis and gradual dose reduction has been addressed. B. Current residents on Psychotropic Medications will be reviewed to determine if appropriate diagnosis, gradual dose reduction has been completed appropriately, and behavior monitoring is being documented in the electronic pharmacy system to reflect resident behaviors. C. Licensed Nursing staff and pharmacist will be educated regarding need for appropriate psychotropic	

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F 758	Continued From page 81 dated 2011 documented: - When antipsychotic therapy is initiated, the patient is monitored quantitatively and qualitatively to determine effectiveness of the medication and the presence of adverse reactions, as specified in the procedure. - Gradual dose reduction is attempted with all patients who received antipsychotic medications, unless clinically contraindicated...Gradual dose reduction of antipsychotic medication is accomplished by decreasing the dose of medication by at least 10% per month after the first three to six months of therapy. The facility's policy entitled Management of Behavioral or Psychological Symptoms of Dementia...with or without Antipsychotic, last reviewed on 1/6/16, stated, "...Procedure: ...5. Critical Thinking Related to Antipsychotic Drug Use...The resident should only be given medication if clinically indicated and as necessary to treat a specific condition and target symptoms as diagnosed and documented in the record. Resident who use antipsychotic drugs must receive gradual dose reductions and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs...". 1. The following was reviewed in R7's clinical record: 7/13/17 - Mental health provider note from community assisted living record: patient is tired and irritable and agitated; re-evaluated for irritable behavior, decrease Remeron dose to 15 mg, start Abilify 2.5 mg to 5 mg in 7 days. There was no discussion of delusions and paranoia in this assessment.	F 758	medication attempted gradual dose reductions based on behavior monitoring. Behavior monitoring tool has been updated to reflect behaviors associated with specific medication classes. D. An audit of 5 residents with Psychoactive Medication orders will be completed weekly for 4 weeks and monthly for 2 months to ensure appropriate diagnosis, gradual dose reduction attempts, and behavior monitoring are present. All audit results will be forwards to the Quality Assurance Process Improvement team for review and recommendations.	

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F 758	Continued From page 82 8/22/17 - Admission orders for Aripiprazole (Abilify) 5 mg diagnosis of dementia with behavioral disturbance / dx dementia with delusions, Celexa 40 mg qd for MDD. Remeron 15 mg for MDD and Lexapro 5 mg for MDD. 8/29/17 Admission MDS - Antipsychotic and antidepressant use daily and diagnoses of anxiety and depression. 9/6/17 - Resident Care Guide did not include any references to behaviors. 9/7/17 Care plan - R7 has inappropriate behavior of yelling, resistive to care, combative, resistive to eating related to dementia; goal - will not exhibit behaviors more than 3x a week through next review; approaches include: psych consult, maintain quiet, relaxed atmosphere to decrease confusion, calm gentle approach, explain all cares before doing, administer and monitor meds as ordered, behavior monitoring and record episodes each shift with interventions, encourage participation in appropriate activities, leave alone and reapproach later when combative / resistive. 9/7/17 Care plan - R7 requires use of psychotropic med to manage mood and/or behavior issue. Resident is on antipsychotic, and antidepressant. Dementia with hallucinations, delusions, behavior disturbance. Goal: R7 will respond cooperatively to behavior interventions resulting in maintenance on lowest therapeutic dose of medication and will not show side effects of medicaton thru next 90 days. Interventions included: monitoring of side effects and attempt / initiate gradual dos reduction as recommended by pharmacist as ordered by MD.	F 758		

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F 758	Continued From page 83 The care plans failed to address how R7 presented with hallucinations and delusions and failed to include individualized non-pharmalogical approaches. 9/7/17 10:11 AM - ID note for risk meeting documented: antipsychotics medication reviewed. Resident currently receives Abilify, Celexa, Lexapro and Remeron with diagnosis of unspecified dementia with behaviors and depression. Date of last gradual dose reduction was done 8/22/17. Date of last pharmacist review 7/31/17. Targeted symptoms/behaviors are aggression and depression. Symptoms/behaviors since last review have improved. Non-pharm interventions include music, staff company, family visits and have been effective. IDT recommends resident needs current medication. The facility failed to identify that R7 did not have dose reduction of Abilify and failed to quantify the decline in behaviors. 9/15/17 - Order for Remeron 7.5 mg for MDD decreased from 15 mg and Lexapro discontinued. 9/15/17 - Mental health provider initial consultation: dementia with behavioral disturbance, MDD recurrent-severe, delusional disorder, paranoid. It was unclear in reviewing the record how R7 presented with delusional disorder and paranoia and what approaches should be used if these behaviors are displayed. 11/27/17 Quarterly MDS - Antipsychotic and antidepressant use daily and diagnoses of anxiety	F 758		

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F 758	Continued From page 84 and depression. 12/22/17 - Mental health provider note patient on low dose Abilify in addition to Celexa as adjunct treatment for MDD x low dose Remeron for decreased appetite with effective management of dementia, delusions and MDD as well as increased appetite with effective management of dementia, delusions and MDD as well as increased appetite. 12/27/17 - Mental health provider note "continue current plan and meds". 8/22/17 - 1/31/18 - Task Administration Record included behavior monitoring "document behaviors and any side effects for psychotropic medications". The following behaviors were documented: 8/23/17 biting x5; 8/27/17 agitated x1 and uncooperative x4 and 11/3/17 agitated x1. 2/2/18 - 2/6/18 General observations all with no behaviors: 2/2/18 2:21 PM - in chair in living room 2/5/18 9:21 AM - in main dining room eating breakfast with encouragement from staff 2/5/18 9:46 AM - in wheelchair in dayroom 2/5/18 10:20 AM - in dayroom 2/5/18 11:06 AM - in dayroom 2/5/18 11:48 AM - in dayroom 2/5/18 01:51 PM - in dayroom 2/6/18 between 8:30 AM and 10:39 AM - in main dining room and and then to dayroom 2/6/18 1:20 PM - Interview with E37 (LPN) revealed that staff were told when R7 came to the facility that s/he was very resistive to care, fought with staff and slapped at the assisted living staff.	F 758		

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F 758	Continued From page 85 When asked were behaviors were monitored E37 revealed that it was in the yellow binder. In reviewing the binder there were no behavior sheets for the resident. E37 stated that behaviors are also documented on the MAR. E37 went on to say that R7 has not been having any behaviors. 2/7/18 9:35 AM - Interview with E3 (ADON) revealed that R7 was admitted to the facility from the assisted living on the antipsychotic medication. E3 stated that there had been a dose reduction since admission but that could not be supported by the clinical record. When asked about behavior monitoring, E3, referred the surveyor to the behavior monitoring book. When told that this resident did not have anything the behavior monitoring book it was revealed that they would not start a monitor until the resident started exhibiting the behavior. E3 stated that the behaviors for the medications would also be documented in the MAR. When asked about the delusions and paranoia, no further information was available. 2/8/18 2:03 PM - Interview with E24 (LPN) and E37 about delusions and paranoia for R7 it was revealed that the only thing they can think of is the resident mentioning her husband is with another woman and the resident not liking to share the dining room table with other residents when he is visiting. R7 was on antipsychotic medication in absence of adequate indication for use and without adequate monitoring. Although mental health professionals documented delusional disorder and paranoia there was no evidence of behaviors related to these diagnoses even prior to starting	F 758		

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F 758	Continued From page 86 the medication. 2. Review of R24's clinical record revealed the following: 9/13/17 - R24 was admitted to the facility with diagnosis of dementia without behavioral disturbance. 9/13/17 - R24 was care planned for psychotrophic medications, including antipsychotic, antianxiety and antidepression. R24's goal was to be free of anxiety and depressive behaviors and adverse effects of the medications. The care plan's approaches included, but not limited to: - consult psych group and follow up as necessary; and - monitor and document all behaviors related to anxiety, depression such as episodes of tearfulness, withdrawal from friends and family. It was unclear in R24's clinical record as to what was the targeted behavior the facility identified and was monitoring for her antipsychotic medication, Risperdal. 11/28/17 at 12:41 PM - A nurse's note stated that R24 was not exhibiting any behaviors and was ordered a gradual dose reduction for Risperdal by the physician. 12/29/17 - The facility's pharmacist conducted a monthly medication regimen review and made the following recommendation to R24's physician: a diagnosis was needed for Risperdal, monitoring for behavior and side effects. The handwritten facility response to the pharmacist's recommendation stated that R24 had behavior monitoring in place. It was unclear upon review of R24's clinical record as to the appropriately	F 758		

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F 758	Continued From page 87 diagnosed condition for Risperdal and what the targeted behavior the facility was monitoring with respect to her Risperdal medication. Review of R24's clinical record from admission on 9/13/17 to 1/29/18 revealed a lack of evidence of any psychological consults. 2/12/18 at 4 PM - Findings were reviewed during the exit conference with E1 (NHA) and E2 (DON). The facility failed to ensure that R24 was treated for an appropriately diagnosed condition for Risperdal and, in addition, failed to identify and monitor the targeted behavior for the antipsychotic medication. 3. Review of R55's clinical record revealed the following: 12/7/17 at 2:18 PM - Review of R55's Summary of Your Hospitalization listed a recommended medication list, which included Seroquel, an antipsychotic medication, for an "indication unknown". The Summary also stated, "This is subject to change based on your doctor's recommendations." 12/7/17 - R55 was admitted to the facility for short-term rehabilitation with a diagnosis of dementia. 12/11/17 - R55 was care planned for psychotrophic medications, including an antipsychotic medication related to dementia with behavior disturbance. R55's goal was to be free of behaviors and adverse effects. The care plan's approaches included, but not limited to: - consult psych group and follow up as necessary; and	F 758		

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F 758	Continued From page 88 - monitor and document all behaviors related to dementia. It was unclear in R55's clinical record as to what was the targeted behavior the facility identified and was monitoring for with respect to her antipsychotic medication, Seroquel. 12/12/17 - Review of R55's physician-signed POS revealed that Seroquel was ordered on admission to the facility but lacked evidence of a clinically indicated diagnosis. 12/27/17 - R55's Psychiatry Initial Consultation stated that her psychiatric diagnosis was dementia with behavioral disturbance and adjustment disorder with mixed anxiety and depression; psychotrophic medication was Seroquel daily; mild cognitive loss; decreased energy; decreased appetite; mild to moderate depression; no psychotic features/hallucinations/delusions; exhibited anxiety; coherent speech; logical thought process; depressed and angry mood. The consult also stated that R55 reported anxiety, depression and anger secondary to being in a new environment. The diagnosis was adjustment disorder with mixed anxiety and depressed mood. The recommendation was for an anti-anxiety medication. It was unclear as to what the facility identified as R55's clinical indication for Seroquel and the targeted behavior to monitor. 1/18/18 - R55's Psych Consult stated that she was seen and evaluated for mental health assessment and dementia evaluation. The Consult stated that R55's diagnosis was dementia with behavioral disturbance and her medications were reviewed, including her antipsychotic medication, Seroquel. Under the	F 758		

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F 758	Continued From page 89 plan, the consult stated that the medication benefits outweigh the risk and to continue her current medications. R55's evaluation revealed mild to normal cognition with stable mood. R55 reported anxiety and anger because she had anticipated being discharged home. It was unclear as to what the facility identified as R55's clinical indication for Seroquel and the targeted behavior for monitoring. 1/24/18 - R55's Psych Consult stated that she was seen and evaluated for follow up on mood, behavior and cognition and her diagnoses were dementia with behavioral disturbance and anxiety disorder. R55's medications were reviewed, which included her antipsychotic medication, Seroquel. There were no reports of increased anxiety or agitation exhibited by R55. Under the plan, the consult stated that medication benefits outweigh risk; R55's mood was stable; reports mild anxiety secondary to wishing to be home; no intervention recommended; and to continue current plan and medications. It was unclear as to what the facility identified as R55's clinical indication for Seroquel and the targeted behavior to monitor. 2/12/18 at 4 PM - Findings were reviewed during the exit conference with E1 (NHA) and E2 (DON). For R55, who was admitted on Seroquel from the hospital on 12/7/17 for an "indication unknown", the facility failed to ensure that they identified and treated an appropriately diagnosed condition for Seroquel; and failed to identify and monitor the targeted behavior for Seroquel. Findings reviewed with E1 (NHA), E2 (DON), E3 (ADON), E4 (RNAC), E20 (ED), and E32 (RCN), on 2/12/18 at approximately 4:00 PM.	F 758		

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	085032		C 02/12/2018

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F 760	Severity/Scope = 2/2 Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, record review, interview and review of product information, it was determined that the facility failed to ensure residents were free from significant medication errors for two (R361 and R313) out of 34 sampled residents. For R361, the facility failed to administer Humalog and Lantus insulin on the evening of admission. The resident experienced elevated blood sugars and was admitted back to the hospital with DKA. For R313, the facility failed to adhere to the product information for Novolog, thus, failed to administer the insulin within the acceptable timeframe. Findings include: The facility's Back-up Pharmacy Policy effective 5/2/16 documents: Upon receipt of medication order from Westminster Village Dover and a determination made that there is an emergent need for a timely delivery of this medication for administration to a patient, either by electronic message through IMAR or a phone call from the facility, The (name of pharmacy) will transfer the order to a local pharmacy and deliver... 1. Cross refer F684, example #2. The following was reviewed in R361's record: R361 was admitted to the facility on 10/31/17 at 5:30 PM with diagnoses which included diabetes (DM), CHF, altered mental status, COPD, history	F 760	A. R361 is no longer at the facility. R313 blood sugars obtained and had no symptoms of hypoglycemia. B. Current residents with insulin orders will be reviewed for any episodes of hypo/hyperglycemia in the past 7 days, if had an episode the physician was notified, and that the medications were available for administration. C. Licensed Nursing staff will be educated to obtain medications from the omnicell and will obtain medications promptly from pharmacy as needed. Education will also include proper timing of insulin administration. D. An audit of 5 residents with insulin orders will be completed for 4 weeks and then for 2 months to ensure that insulin was administered at the appropriate time in relation to meals, that the medications were available for administration, that the resident did not have any episodes of hypo/hyperglycemia, and if there was a hypo/hyperglycemic episode that the physician was notified. An audit of 5 new admissions or re-admissions records will be completed for 4 weeks and then for 2 months to ensure that medications ordered were available and administered in the ordered time frame. All audit results will be forwarded to the Quality Assurance	4/2/18

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F 760	Continued From page 91 of kidney transplant, recent UTI with sepsis, and lung cancer. The following was reviewed in R361's clinical record: 10/31/17 6:53 PM - ID note - Resident admitted from (hospital name) at 5:30 PM....alert and oriented x2 with periods of confusion. Review of body system done and medications verified with the primary care physician. 10/31/17 - Admission orders included but were not limited to: Humalog insulin at meal times; 10u at breakfast, 16u at lunch and 18u at dinner For DM; Lantus insulin 52u at bedtime for DM; There was no order for the frequency of FSBS, any parameters for blood sugar readings and no sliding scale insulin orders to cover elevated blood sugars. 10/31/17 - MAR documented the Lantus insulin was not administered "pending pharmacy delivery". The Humalog insulin was not on the October MAR to administer with dinner even though the resident arrived at dinner time. It was transcribed to start on 11/1/17 with breakfast. Review of the Omnicell and E-kit [stock medications] content lists revealed the Lantus was available on the unit. Review of MAR and POS lacked evidence that a FSBS was done on 10/31/17 (dinner and bedtime, indicated on MAR with ordered insulin) after admission to the facility. The MAR listed the Lantus to be administered at 9:00 PM but documented it was not administered because it had not arrived from the pharmacy. 11/1/17 - MAR documented the FSBS at	F 760	Process Improvement team for review and recommendations.	

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F 760	Continued From page 92 breakfast - 489, lunch - 435, dinner 489 and bedtime 491. There was no evidence that the elevated BS was addressed or that the MD was contacted. 11/2/17 3:01 AM - ID note documented vital signs WNL. 11/2/17 10:08 AM - ID note documented: This nurse informed by the CN that the residents blood glucose check is reading high with ketones went to assess resident, resident diaphoretic with chills bedding soaked from sweat, he had received 10 units of insulin rechecked blood glucose level still reading high with ketones... 11/2/17 10:16 AM - ID note documented: Upon assessing this patient he appeared to be clammy and had vomited. Pt. finger stick read "Hi" ketones on the glucometer, pt was given 10 units of Humalog as ordered. This did not lower his glucose after being checked again...E9 (MD) was then called and ordered to send the pt. to (hospital name)... 11/2/17 11:17 AM - ID note documented; Received call from (lab name) at around 10 AM in the process of getting ready to send resident to the hospital that the glucose (from morning lab work) was 700... 11/2/17 - Review of hospital records revealed the resident had diagnoses of hyperglycemia, DKA, fever of unclear source, mild hyperkalemia and acute renal failure status post kidney transplant. 2/08/18 2:27 PM - Interview with E36 (LPN) revealed that the list of medications available on the unit were on the side of the medication	F 760		

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F 760	Continued From page 93 storage unit, the list included a bottle of Lantus insulin. E36 stated that at all nurses have access to these medications. 2/08/18 2:51 PM - Interview with E2 (DON) revealed that she did not remember this resident and would have to review the chart. 2/09/18 09:56 AM - Interview with E5 (RN) and E4 (RNAC) revealed that nurses should get medications from the Omnicell when they have not been delivered from the pharmacy. It was also revealed that if a FSBS is >400 the MD should be consulted and the doctor usually has a sliding scale insulin order on the residents record. 2/09/18 10:38 AM - Interview with E7 (LPN) stated on 11/2/17 the lab had been in around 7:30 AM to draw R361's blood and it would have been around 8:30 - 9:00 AM when she got to the resident to do the morning BS and insulin. E7 revealed that the documentation of a 0 for FSBS was an error on 11/2/17 it was actually reading "Hi". She added the resident was diaphoretic and clammy when she was doing her morning rounds. The doctor was called and the resident was to go to the ED. Around the same time the lab called with a critically high BS reading of 700. When asked at what FSBS would she contact the MD, E7 stated it depends on their individual scale but round 380 to 400. E7 was asked to check the MAR for a scale and it was revealed that there was no scale for the resident 10/31 - 11/2/17. 2/09/18 11:34 AM - Interview with E9 revealed that he did not remember this resident but generally he would expect a call for FSBS >400 and <60 and if the reading is 400 - 450 a change in insulin may be made with a reassessment the	F 760		

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F 760	Continued From page 94 next day. When asked about the Lantus not being administered E9 stated that he should have been consulted, usually the facility calls him. 2/09/18 12:08 PM - Interview with E6 (LPN) revealed she remembers R361 being up, talking and oriented on 11/1/17 into 11/2/17 because she worked 3 - 11 PM and stayed over into the next shift. The note she wrote at 3:00 AM was just vital signs and no FSBS was done. 2/09/18 4:21 PM - Interview with E1 (NHA), E2, E20 (Executive Director), and E32 (Corporate nurse) revealed that the facility had no formal hyperglycemia protocol or policy. It was revealed that the physician's usually write their own parameters for insulin and contacting the physician for high and low BS. The above findings were reviewed and no further information was provided. The facility offered no further information on the concerns expressed on 2/11/18 prior to exit. The facility failed to administer ordered insulin upon admission to the facility and failed to identify elevated BS requiring reassessment and physician consultation. This resulted in R361 being admitted to the hospital with hyperglycemia / DKA. 2. During medication observation on 2/8/18 at 4:11 PM, E7 (LPN) administered Novlog insulin, 5 units for a fingerstick blood sugar reading of 321 to R313. An interview with E7 immediately after the observation revealed that the dinner delivery to the unit was scheduled for 5:30 PM, approximately one hour and fifteen minutes later. At approximately 4:15 PM, surveyor interviewed E17 (RN Supervisor), who verbalized that	F 760		

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F 760	Continued From page 95 Novolog insulin can be administered up to 30 minutes prior to the meal. During this interview, the surveyor requested for the facility to provide the information. Upon retrieving the Novolog product information, it was revealed that the insulin should be administered no more than 5 to 10 minutes before the meal. E17 immediately notified E7 of this information and E7 offered and R313 consumed half of a tuna sandwich. At 5:35 PM, the meal cart arrived in the unit and at 5:38 PM, R313 was provided her dinner. Findings reviewed with E1 (NHA), E2 (DON), E3, E4, E20 (ED), and E32 (RCN), on 2/12/18 at approximately 4:00 PM. Severity/Scope = 3/1	F 760		
F 814	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain the garbage disposal area clean and free of debris, to prevent the harborage of pests. Findings include: During a tour of the garbage disposal area with E31 (Director of Environmental Services) on 2/7/18 at 10:30 AM, receptacles for recyclables and construction materials, and a large compactor were observed. According to E31, trash from the healthcare facility was placed in the compactor daily. Inspection of the trash compactor area revealed debris below and around the compactor.	F 814	A. The trash dumpster area was cleaned on 2/8/18. B. There were no residents affected by this finding. C. The area will be checked by the maintenance staff daily for loose garbage, open doors, lids, and cleaned as needed. D. An audit will be completed weekly by the Director of Maintenance or designee for 4 weeks and then monthly for 2 months of the dumpster area. Audit results will be forwarded to the Quality Assurance Performance Improvement committee for review.	4/2/18

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F 814	Continued From page 96 These findings were reviewed with E1 (NHA), E2 (DON), E20 (Executive Director), and E32 (Regional Corporate Nurse) on 2/9/18 at 3:15 PM. Severity/Scope = 2/1	F 814		
F 880	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;	F 880		4/2/18

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F 880	Continued From page 97 (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, 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 establish and maintain an infection prevention and control program. The facility failed to follow	F 880	A. R312 has been discharged home and had no ill effects. B. Current residents with isolation precautions will be reviewed to ensure	

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F 880	Continued From page 98 infection control transmission based precaution for R312, who was on respiratory droplet precaution due to influenza [flu]. Findings include: On 1/31/18 at approximately 12:50 PM, E33 (ADD) knocked on the door of R312 and entered room without applying indicated PPE to review the menu selections with the resident. E33 was observed sitting in a chair, across from the resident, within three feet distance from R312. At 12:52 PM, surveyor advised E17 (RN Supervisor) of the above observation and E17 immediately advised E33 of the droplet precaution. E33 immediately washed his hands and exited the room. An interview with E33 at 12:57 PM revealed that he thought the sign was to Stop and knock before entry and did not read the poster, that was taped on the entry room door The sign documented "STOP Important before you continue. All visitors must speak with nurse before entering this resident room before entry." An interview with E17 at approximately 1:00 PM confirmed that R312 remained on droplet precaution and personal protective equipment including mask, gown, and gloves would be needed. Findings reviewed with E1 (NHA), E2 (DON), E3, E4, E20 (ED), E32 (RCN), on 2/12/18 at approximately 4:00 PM. Severity/Scope = 2/1	F 880	proper personal protective equipment is being utilized. C. Current staff has been educated on 2/8/18 regarding infection control isolation precautions and proper use of personal protective equipment D. An audit of 3 residents with isolation precautions will be completed weekly for 4 weeks and then monthly for 2 months to ensure that appropriate personal protective equipment is being utilized. All audit results will be forwarded to the Quality Assurance Process Improvement team for review and recommendations.	

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

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

STATE SURVEY REPORT

NAME OF FACILITY: Westminster **DATE SURVEY COMPLETED: February 12, 2018**

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 and complaint survey was conducted at this facility from January 31, 2018 through February 12, 2018. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and other facility documentation as indicated. The facility census the first day of the survey was 34. The survey sample totaled thirty-four (34).		
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 survey completed February 12, 2018: F578, F580, F641, F655, F656, F679, F684, F686, F689, F692, F695, F711, F756, F758, F760, F814 and F880.	Cross Refer to the CMS 2567-L survey completed February 12, 2018 and POC submitted March 8, 2018: F578, F580, F641, F655, F656, F679, F684, F686, F689, F692, F695, F711, F756, F758, F760, F814 and F880.	4/2/2018

Provider's Signature [signature] NHA Title Assistant Exec. Dir. Date 3/8/18