STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	085053		C 10/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MOORINGS AT LEWES	17028 CADBURY CIRCLE LEWES, DE 19958

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced annual and complaint survey was conducted at this facility from October 15, 2018 through October 24, 2018. The facility census the first day of the survey was 38 (thirty eight). An emergency preparedness survey was also conducted during the same time period. There were no emergency preparedness deficiencies based on observation and interviews.	E 000		
F 000	INITIAL COMMENTS An unannounced annual and complaint survey was conducted at this facility from October 15, 2018 through October 24, 2018. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records, review of facility policies and procedures and review of other facility documentation as indicated. The facility census the first day of the survey was 38 (thirty eight). NHA - Nursing Home Administrator; DON - Director of Nursing; ADON - Assistant Director of Nursing; RN - Registered Nurse; LPN - Licensed Practical Nurse; MD - Medical Doctor; NP - Nurse Practitioner; RNAC - Registered Nurse Assessment Coordinator; CNA - Certified Nurse's Aide; NP - Nurse Practitioner; SW/SS-social worker/social service; AED (automated external defibrillator) - portable electronic device that automatically diagnoses life-threatening heart rates or rhythms and is able to treat them through the application of electricity; Activities of daily living (ADL's) - tasks needed for	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/21/2018

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	085053		C 10/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MOORINGS AT LEWES	17028 CADBURY CIRCLE LEWES, DE 19958

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 1 daily living, e.g. dressing, hygiene, eating, toileting, bathing; Antidepressant - drug to treat depression; Anticoagulant - medication to prevent blood clots; Antipathetic - drug to treat psychosis and other mental/emotional conditions (e.g. Risperdal, Seroquel); Anxiety - feeling worry, nervous or restless; Aphasia - condition affecting language; Bacteria - germs that can cause disease; Bilateral - both sides; Blanchable - skin loses redness/turns white when pressed with finger (better than non-blanchable); BM - bowel movement; Braden Scale - standardized assessment tool used to assess risk for developing pressure ulcers; cm (centimeters) - unit of length; BIMS-assessment to evaluate mental cognition; Cognition-thinking, memory; CT scan - Computed Tomography scan/use of computer-processed combinations of many X-ray measurements taken from different angles to produce cross-sectional (tomographic) images (virtual "slices") of specific areas of a scanned object, allowing the user to see inside the object without cutting; DNR ("Do Not Resuscitate") - written instructions from a doctor telling health care providers not to perform Cardiopulmonary Resuscitation (CPR); Dehydration - a condition when the body has less than normal fluid; Delusions - a type of serious mental illness called a "psychosis" in which a person cannot tell what is real from what is imagined; Depression - mood disorder with feelings of sadness; Edema - swelling; e.g. - for example;	F 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	085053		C 10/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MOORINGS AT LEWES	17028 CADBURY CIRCLE LEWES, DE 19958

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 2 EMR - electronic medical record; eMAR - electronic medication administration record; Enteral feeding tube - flexible tube going to the stomach for feeding; eTAR/TAR - electronic treatment administration record/treatment administration record; Full Code - means to intercede if a patient's heart stops beating or if the patient stops breathing. It is the opposite code of DNR (Do Not Resuscitate); Hospice - end of life care; HOB-head of bed; I&O - input and output; Incontinence - inability to control bladder and/or bowel; Integrity - health and condition of skin; i.e.-that is; Off-load (ed, ing) - reduces pressure of the heels; MDS (Minimum Data Set) - standardized assessment forms used in nursing homes; mg (milligrams) - unit of weight; mL (milliliters) - unit of volume; MMR - Medication Regimen Review; Narcotic - pain relief medication; Plavix - antiplatelet drug/prevents platelets in your blood from sticking together to form an unwanted blood clot that could block an artery; used to lower one's risk of having a stroke, blood clot, or serious heart problem; POA - Power of Attorney; Pressure ulcer/injury - April, 2016 - National Pressure Ulcer Advisory Panel (NPUAP) pressure ulcer guidelines defined a pressure injury / ulcer as localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of	F 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	085053		C 10/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MOORINGS AT LEWES	17028 CADBURY CIRCLE LEWES, DE 19958

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 3 intense and/or prolonged pressure or pressure in combination with shear. The ability of the soft tissue to tolerate pressure and shear may also be affected by microclimate (temperature, moisture of area), nutrition, perfusion (blood supply), co-morbidities (disease, illness) and condition of the soft tissue; Pressure Ulcer/injury classification system: - Stage 1 Pressure Injury: Intact red skin often over a boney area that does not turn white / light (does not blanche) when pressed. - Stage 2 Pressure Injury: Blister or shallow open sore with red/pink color. Deeper tissues/fat, granulation tissue, slough and eschar are not present. - Stage 3 Pressure Injury: Open sore that goes into the tissue under below the skin. How deep it is depends on the amount of tissue under the skin. Fat, granulation tissue and rolled edges are often present. Little slough and/or eschar may be visible but does not hide the extent of tissue loss. - Stage 4 Pressure Injury: Open sore so deep that muscle, tendons, ligaments, cartilage or bone can be seen. Rolled edges, undermining, tunneling often occur. Slough or eschar may be visible. - 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. Once slough/eschar removed, a Stage 3 or 4 injury will be revealed. Stable eschar (i.e. dry, adherent, intact without redness or movement) on the heel or limb with impaired blood flow should not be softened or removed. - Deep Tissue Pressure Injury (DTI): Intact or non-intact deep red, maroon, purple discoloration that does not turn white/light when pressed or	F 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	085053		C 10/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MOORINGS AT LEWES	17028 CADBURY CIRCLE LEWES, DE 19958

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 4 skin separation revealing a dark wound bed or blood filled blister. Pain and temperature change often appear before skin color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/ PRN - as needed; Psychiatrist - physician treating mental disorders; Psychosis/psychotic- loss of contact/touch with reality; Psychotropic (medication) - medication capable of affecting the mind, emotions and behavior; Skin prep - topical wound care treatment; STAT-immediately; T - temperature; Urinary Tract Infection (UTI) - urine infection; UTD - unable to determine; > - more than; < - less than; = - equal; + - plus; %-percent; x - times.	F 000		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(I) Personal privacy includes accommodations, medical treatment, written and	F 583		12/21/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	085053		C 10/24/2018

NAME OF PROVIDER OR SUPPLIER
THE MOORINGS AT LEWES

STREET ADDRESS, CITY, STATE, ZIP CODE
17028 CADBURY CIRCLE
LEWES, DE 19958

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 583	Continued From page 5 telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation it was determined that the facility failed to provide privacy of resident health information for two (R41 and R29) out of 35 sampled residents. Findings include: 10/15/18 around 1:00 PM - Interview with F1 (family member of a current resident) , who wished to remain anonymous, stated that "staff talk loudly at the nursing station about other residents."	F 583	F583: Personal Privacy /Confidentiality of Records A. Individual/Resident Impacted • The corrective action taken for the residents found to have been affected by the deficient practice on 10/15/18 and 10/19/18: Resident R29 was discharged to another facility and no longer resides in SNF. R41 continues as a resident. Nursing staff attended a HIPPA in-service on 10/26/18 conducted by the Cooperate	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	085053		C 10/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MOORINGS AT LEWES	17028 CADBURY CIRCLE LEWES, DE 19958

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 583	Continued From page 6 1. 10/15/18 at 1:35 PM - E9 (LPN) was observed on the telephone at the nursing station arranging a diagnostic test for R41. The nurse spelled the resident's last name which was heard in the conference room across the hallway. 2. 10/19/18 at 12:15 PM - E26 (LPN) was observed giving report in person at the nursing station for R29, who was discharging to another facility. The nurse spelled R29's last name which was heard in the conference room across the hallway including "this is about her butt." This finding was reviewed during the exit conference on 10/24/18 beginning at 1:00 PM with E1 (NHA), E2 (DON)and E8 (Staff Educator) in person, and E4 (Clinical Analyst), E5 (Regional Nurse Consultant) and E23 (Corporate Administrator) by telephone.	F 583	Compliance Officer to review policies and procedures related to healthcare. Nursing staff also attended a staff meeting that addressed the protection of privacy and confidentiality of PHI (personal health information) on 11/19/18. • The HIPAA in-service conducted for all staff working on SNF B. Identification of other residents with the potential to be affected • All residents are at risk to be potentially affected by the deficient practices C. System Changes • The root cause analysis identified that remedial training of HIPPA and PHI policies and procedures needed to be implemented immediately. All licensed nursing personnel and ancillary staff will be in-serviced by 12/21/2018 on HIPAA and the safeguarding of PHI. • Monthly staff meetings will be conducted by the DON/Designee on HIPAA compliance and voice volume control. (See Attachment 1) • Management will acquire a noise level meter for the existing nurse station which will alert staff on the desk when voices are too loud. (See Attachment 2) D. Success Evaluation • Random observations of the nursing station while staff is on duty will be conducted by the DON/designee daily x 4 weeks, and then twice per week for two weeks, and then weekly to ensure resident privacy and confidentiality is	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	085053		C 10/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MOORINGS AT LEWES	17028 CADBURY CIRCLE LEWES, DE 19958

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 583	Continued From page 7	F 583	being protected. The expectation is that 100% compliance will be obtained once all staff has been trained on HIPPA and PHI policies and procedures. All audit results will be reported at the monthly QAPI meeting.	
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);	F 584		12/27/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	085053		C 10/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MOORINGS AT LEWES	17028 CADBURY CIRCLE LEWES, DE 19958

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 8 §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility failed to provide a home-like environment when the call light system produced a loud, screeching, piercing alarm when residents used their call light in their rooms. Findings include: 10/15/18 - 10/24/18 - During the survey when residents activated their call light a constant screeching, high-pitched tone was audible at the nursing station and at the resident's room creating an environment that was not homelike. The sound stopped when staff turned off the call light in the residents' room. 10/22/18 (around 8:10 AM) - During an interview regarding the noise from the call light system, E4 confirmed the sound was piercing and was not homelike. This finding was reviewed during the exit conference on 10/24/18 beginning at 1:00 PM with E1 (NHA), E2 (DON)and E8 (Staff Educator) in person, and E4, E5 (Regional Nurse Consultant) and E23 (Corporate Administrator) by telephone.	F 584	F584: Safe/Clean/Comfortable/Homelike Environment A. Individual/Resident Impacted • The corrective action taken for all residents found to have been affected by the deficient practice. Director of Support Services/Designee is responsible for the corrective action and immediately modified the call bells tone. B. Identification of other residents with the potential to be affected • All residents are at risk to be potentially affected by the deficient practices. C. System Changes • Ceiling mounted call lights have an audible alert that has been silenced as of 11/19/2018 for all devices. • Provide in-service training for all employees by 12/21/2018 on how to appropriately respond to the current call bell system, through the visual indicator lights or via individual pagers that are released to the CNAs every shift. • Director of Support	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	085053		C 10/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MOORINGS AT LEWES	17028 CADBURY CIRCLE LEWES, DE 19958

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 9	F 584	Services/Designee to conduct a monthly test of the call light system for function. D. Success Evaluation • Administrator/Designee will conduct monthly audits x 6 months on the call bell response report until a response time within 5 minutes for at least 80% of the calls will be achieved as practicable. • Results of audits will be reviewed during QAPI meetings. QAPI committee will identify trends and make recommendations based on audit results.	
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all	F 609		12/21/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	085053		C 10/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MOORINGS AT LEWES	17028 CADBURY CIRCLE LEWES, DE 19958

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 10 investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and review of other facility documentation it was determined that the facility failed to report an allegation of mistreatment to the State Agency in a timely manner for one (R9) out of 3 sampled residents. Findings include: 9/15/18 - R9 made an allegation of mistreatment which occurred around 8:00 PM. Review of facility investigation documents revealed the State Agency was not notified until 9/25/18 at 4:24 PM, 10 days after the allegation. 10/22/18 (5:15 PM) - During an interview, E2 (DON) confirmed the late reporting to the State Agency. This finding was reviewed during the exit conference on 10/24/18 beginning at 1:00 PM with E1 (NHA), E2 and E8 (Staff Educator) in person, and E4 (Clinical Analyst), E5 (Regional Nurse Consultant) and E23 (Corporate Administrator) by telephone.	F 609	F609 Reporting of Alleged Violations A. Individual/Resident Impacted • The corrective action taken for the resident (R9) found to have been affected by the deficient practice. • The DON/Designee is responsible to ensure the timeliness of reportable events to be reported to the DLTCRP following the current guidelines. B. Identification of other residents with the potential to be affected • All residents are at risk to be potentially affected by the deficient practices. C. System Changes • Conduct in-service training by 12/21/2018 for all staff on the process of the reportable event as outlined by the DLTCRP. • Administrator/Designee will conduct an audit of all reportable events. (See Attachment 4) D. Success Evaluation • DON/Designee will review all events, which will be reported on monthly QAPI. • All reportable events are reported to quarterly to the Professional Services Committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	085053		C 10/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MOORINGS AT LEWES	17028 CADBURY CIRCLE LEWES, DE 19958

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, interview and review of other facility documentation it was determined that the facility failed to thoroughly investigate allegations of mistreatment for three (R9, R46 and R97) out of 35 sampled residents. Findings include: The facility policy entitled Resident Abuse (last revised 6/26/17) included that the nursing supervisor on duty shall immediately report any alleged violations of this prevention policy to the administrator or designee. The nursing supervisor will assess the resident. The Administrator or designee will interview the resident as well as all nursing, housekeeping, laundry, dietary, activity staff, and any visitors or others that may have knowledge of the occurrence or who may have	F 610	F610 (1) Investigate/Prevent/Correct Violation A. Individual/Resident Impacted • Resident (R9) was found to have been affected by this deficient practice. • This was unable to be corrected because the incident was already reported to the DLTCRP. The facility will move forward with actions to prevent future occurrences. B. Identification of other residents with the potential to be affected • All residents are at risk to be potentially affected by the deficient practices.	12/26/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	085053		C 10/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MOORINGS AT LEWES	17028 CADBURY CIRCLE LEWES, DE 19958

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 12 been in the vicinity at the time. The administrator and/or nursing supervisor will conduct a thorough investigation. Any employee suspected of violation of these resident abuse policies will be removed from all resident care duties and be suspended pending investigation. Cross Refer F609 1. Review of facility investigation documentation for R9's allegation of mistreatment from 9/15/18 revealed no written statements from CNAs or the medication nurse working at the time of the alleged incident. 10/22/18 (5:15 PM) - Interview with E2 (DON) about R9's allegation revealed the accused was suspended during the investigation and confirmed an internal investigation was not completed since an investigator from the State Agency looked into the allegation. The facility failed to thoroughly investigate R9's allegation of mistreatment. 2. Review of R97's clinical record revealed: Review of facility investigation documentation for R97's allegation of mistreatment and delay of call bell response on 4/5/18 around 6:40 PM revealed: - A grievance was submitted on 4/6/18 when R97 informed the facility of the allegation; - R97 activated the bathroom call light at 6:33 PM; after nearly 6 minutes, E17 (CNA) responded and informed the resident s/he needed to do more for him/herself in order to go assisted living. E17 then left R97 in the bathroom; - The facility's call light log showed R97 immediately re-rang the call light which rang for	F 610	C. System Changes • The facility will follow the guidelines for events that require reporting to the DLTCRP as specified. • The In-service Coordinator/Staff Developer/Designee will conduct an in-service training on the abuse policy and procedure for all staff, to be completed by 12/21/2018. Annual Abuse in-service training will be conducted by the Social Worker/Designee and as needed for employees that are involved in any alleged abuse occurrence. • All new hires will be educated on the Abuse Policy and Procedure during orientation • The Administrator/Designee will conduct an audit of all reportable events prior to submission to DLTCRP. • Administrator/Designee will interview the resident, Social Services or designee will interview all nursing, housekeeping, laundry, dietary, activity staff and any visitors or others that may have knowledge of the occurrence or who may have been in the vicinity at the time. The Nursing Supervisor/Designee will conduct a thorough investigation starting immediately upon becoming aware of an incident and will work to complete the investigation within 5 days and will report all findings and conclusions to the Administrator/Designee. • Social Services will maintain an incident spreadsheet to track incidents, including the alleged incident, the date of incident, the policy violation, an incident number for tracking purposes, any training needed, the date training took place and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	085053		C 10/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MOORINGS AT LEWES	17028 CADBURY CIRCLE LEWES, DE 19958

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 13 over 27 minutes before staff responded; - The resident statement taken by E8 (RN Staff Education) included that, from in the bathroom, R97 saw E17 walking down the hall and going into the room next door. A different staff member (not E17) helped R97 out of the bathroom and back to bed; - A statement from the accused indicated that two call lights were ringing at the same time as R97's, the room next to R97 and the room across the hall from R97. The facility investigation lacked: - written statements from other CNAs and nurses working at the time of the alleged incident; - evidence that call light logs of residents that E17 alleged were on at the same time as R97s; - a 5 day follow up was submitted timely on 4/10/18 to the State Agency, but indicated that extended call bell response time was substantiated with justification due to extenuating circumstances. 3. Review of R46's clinical record revealed: 9/24/18 - Admission to facility to treat an infected knee replacement. 9/30/18 - R46 reported an allegation of mistreatment when E17 (CNA) refused to listen on how to transfer the resident and refused to lift R46's legs into bed, which caused the resident pain. 10/1/18 - The admission MDS assessment stated R46 needed extensive assistance with two staff for transfers. 10/2/18 - A concern form was completed by E2	F 610	the conclusion/resolution. • Any training needed would be conducted by the ADON/Designee before employee is put back on the schedule. Staff developer would be contacted by nursing supervisor, Human Resources Manager or designee either in person or by email. D. Success Evaluation • DON/Designee will review all events, which will be reported at the monthly QAPI committee meeting. • All reportable events are reported quarterly to the Professional Services Committee. F610 (2) Investigate/Prevent/Correct Violation A. Individual/Resident Impacted • Resident (R97) was found to have been affected by this deficient practice. B. Identification of other residents with the potential to be affected • All residents are at risk to be potentially affected by the deficient practice. C. System Changes • Ceiling mounted call lights have an audible alert that has been silenced as of 11/19/2018 for all devices. • Provide in-service training for all employees by 12/21/2018 on how to appropriately respond to the current call bell system, through the visual indicator lights or via individual pagers that are	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	085053		C 10/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MOORINGS AT LEWES	17028 CADBURY CIRCLE LEWES, DE 19958

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 14 (DON). 10/15/18 9:09 AM - Interview with E26 (LPN) revealed concern forms were located by the elevator. If a resident had a concern, E26 would provide the form to the resident. If unable to complete the form, two staff nurses would listen to the concern, take notes and complete the form for the resident. 10/15/18 9:16 AM - In an interview, R46 described the incident from 9/30/18 when E17 (CNA) did not listen and refused to lift R46's legs related to R17's "bad back." After R46 told E34 (CNA) about the incident, who then informed the nurse, E17 was moved to another assignment. R46 reported that E34 said there were papers by the elevator to file a grievance/concern and that no one gave him/her a grievance form. 10/16/18 11:30 AM - E2 (DON) supplied this surveyor with a concern form that revealed that R46 just did not like for E17 to take care of him/her and indicated no specific concerns. There were no statements from staff. 10/18/18 9:30 AM - In a follow up interview, R46 repeated the same information about E17 (CNA) not listening and refusing to lift R46's legs into bed, which caused R46 pain. R46 added he/she was cautious about filing a concern form so as to not get anyone in trouble. The facility failed to thoroughly investigate and obtain statements regarding R46's allegation of mistreatment. These findings were reviewed during the exit conference on 10/24/18 beginning at 1:00 PM	F 610	released to the CNAs every shift. • Director of Support Services/Designee to conduct a monthly test of the call light system. • The Social Worker/Designee will attend Resident Council meetings at least once per quarter with permission of the Resident Council to discuss resident call bell response concerns. D. Success Evaluation • The Social Worker/Designee will interview 1 resident per week for the next 12 weeks, then once monthly for the next 6 months to ensure that resident's needs are met in a timely manner. • The Administrator/Designee will obtain monthly call bell reports once monthly for the next six months to audit for timeliness of response, which will be reported on monthly QAPI. Results of audits will be reviewed during QAPI meetings. • All reportable events are reported quarterly to the Professional Services Committee. Results of audits will be reviewed during QAPI meetings. • Results of audits will be reviewed during QAPI meetings. QAPI Committee will identify trends and make recommendations based on audit results. F610 (3) Investigate/Prevent/Correct Violation • Individual/Resident Impacted • Resident (R46) was found to have	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	085053		C 10/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MOORINGS AT LEWES	17028 CADBURY CIRCLE LEWES, DE 19958

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 15 with E1 (NHA), E2 (DON) and E8 (Staff Educator) in person, and E4 (Clinical Analyst), E5 (Regional Nurse Consultant) and E23 (Corporate Administrator) by telephone.	F 610	been affected by this deficient practice. • Identification of other residents with the potential to be affected • All residents are at risk to be potentially affected by the deficient practice. • System Changes • Resident grievances will be investigated immediately by the Social Worker/Designee. • The Social Worker/Designee will provide in-service training to all staff on the grievance/complaint process which will be complete by 12/21/2018. • A copy of our grievance form and complaint procedure will be posted in an accessible area. • The Social Worker/Designee will attend Resident Council meetings at least once per quarter with permission of the Resident Council to discuss resident concerns. • Success Evaluation • The Social Worker/Designee will interview 1 resident per week for the next 12 weeks, then once monthly for the next 6 months until 100% compliance is achieved to ensure that resident's needs and concerns are addressed. • DON/Designee will review all events, which will be reported on monthly QAPI. • All reportable events are reported quarterly to the Professional Services Committee. • The monthly call bell audit will be report on monthly QAPI. • Results of audits will be reviewed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	085053		C 10/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MOORINGS AT LEWES	17028 CADBURY CIRCLE LEWES, DE 19958

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 16	F 610	during QAPI meetings . QAPI Committee will identify trends and make recommendations based on audit results.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to ensure accuracy of MDS assessments for three (R22, R34 and R40) out of 35 sampled residents in the areas of toileting, active diagnoses and medication. Findings include: 1. The following was reviewed in R40's clinical record: 9/27/18 - R40 was admitted to the facility for rehabilitation. 10/3/18 - The admission MDS assessment coded R40 as taking an anticoagulant every day during the 7-day look back period. 9/27/18 through 10/16/18 - eMAR revealed that R40 did not receive any anticoagulants. 10/17/18 3:21 PM - In an interview, E7 (RNAC) confirmed the coding error and stated he/she would submit a correction. E7 stated he/she thought the antiplatelet medication Plavix R40 was taking was an anticoagulant. 2. The following was reviewed in R34's clinical	F 641	F641 (1) Accuracy of Assessments A. Individual/Resident Impacted • The corrective action taken for the resident (R40) found to have been affected by the deficient practice. • The MDS was corrected immediately upon identification of the error by submission of an MDS correction dated 10/3/2018. B. Identification of other residents with the potential to be affected • All residents that are on an anti-coagulant/anti-platelet regimen are at risk to be potentially affected by the deficient practices. C. System Changes • Conducted an audit on 10/17/2018 of all residents on anti-coagulant/anti-platelet regimen and verified proper MDS coding. • The MDS was corrected immediately upon identification of the error by submission of an MDS correction dated 10/3/2018. • The corporate RNAC conducted an in-service training on 11/23/2018 on the	12/26/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	085053		C 10/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MOORINGS AT LEWES	17028 CADBURY CIRCLE LEWES, DE 19958

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 17 record: 9/6/18 - R34 was admitted to the facility for rehabilitation with diagnoses that included mixed anxiety, depressed mood, and anxiety disorder. 9/13/18 - The admission MDS assessment did not include active diagnoses of anxiety or depression for which R34 was taking medication. 10/22/18 2:00 PM - During an interview, E2 (DON) reviewed the MDS coding error. 3. The following was reviewed in R22's clinical record: 9/12/18 - A quarterly MDS assessment coded R22 as being totally dependent on staff for toileting. September, 2018 - Review of CNA documentation revealed toileting should have been coded as "activity occurred only once or twice." 10/17/18 3:20 PM - During an interview, E7 (RNAC) confirmed the coding error and stated a correction would be submitted. These findings were reviewed during the exit conference on 10/24/18 beginning at 1:00 PM with E1 (NHA), E2 (DON) and E8 (Staff Educator) in person, and E4 (Clinical Analyst), E5 (Regional Nurse Consultant) and E23 (Corporate Administrator) by telephone.	F 641	specific regulation identified in the RAI manual (section N.) D. Success Evaluation • The RNAC will conduct a monthly audit for the next 12 months of all residents on anti-coagulant/anti-platelet therapy to ensure 100% accurate MDS coding and will be reported at the monthly QAPI. • Results of audits will be reviewed during QAPI meetings. QAPI Committee will identify trends and make recommendations based on audit results. F641 (2) Accuracy of Assessments A. Individual/Resident Impacted • The corrective action taken for the resident (R34) found to have been affected by the deficient practice. • The diagnosis was corrected immediately to include anxiety and depression upon identification of the error. B. Identification of other residents with the potential to be affected • All residents on psychoactive medications are at risk to be potentially affected by the deficient practice. C. System Changes • The RNAC will conduct an audit by 11/30/2018 of all residents on psychoactive medications and verify there is an active diagnosis coded on the MDS. • The Admissions Coordinator will verify that appropriate diagnoses are documented on the electronic health record.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	085053		C 10/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MOORINGS AT LEWES	17028 CADBURY CIRCLE LEWES, DE 19958

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 18	F 641	• An audit of diagnosis codes will be conducted by the RNAC for every admission within 48 hours. • The corporate RNAC conducted an in-service training on 11/23/2018 on the specific regulation identified in the RAI manual (section I.) D. Success Evaluation • The RNAC will conduct a monthly audit for the next 12 months of all residents on psychoactive medication to ensure 100% accurate MDS coding. • Audit results will be reported at the monthly QAPI meeting. Results of audits will be reviewed during QAPI meetings. QAPI Committee will identify trends and make recommendations based on audit results. F641 (3) Accuracy of Assessments A. Individual/Resident Impacted • The corrective action taken for the resident (R22) found to have been affected by the deficient practice. • The ADL toileting coding was corrected immediately upon identification of the error. B. Identification of other residents with the potential to be affected • All residents are at risk to be potentially affected by the deficient practice. C. System Changes • The RNAC will conduct a monthly ADL coding in-service training to all Certified Nursing Assistants.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	085053		C 10/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MOORINGS AT LEWES	17028 CADBURY CIRCLE LEWES, DE 19958

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 19	F 641	D. Success Evaluation • The RNAC will conduct random audits 1 chart per week for the next 12 weeks and then 1 chart monthly for the next 6 months to ensure 100% accurate ADL coding. • The results of the audits conducted by the RNAC will be reported at the monthly QAPI meeting. Results of audits will be reviewed during QAPI meetings. QAPI Committee will identify trends and make recommendations based on audit results.	
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will	F 656		12/31/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	085053		C 10/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MOORINGS AT LEWES	17028 CADBURY CIRCLE LEWES, DE 19958

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 20 provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, interview and observation, it was determined that the facility failed to develop comprehensive care plans that addressed resident's medical, physical, mental and psychosocial needs and behaviors for six (R17, R18, R22, R34, R36 and R42) out of 35 sampled residents. Findings include: Cross Refer F686 1. Review of R36's clinical record revealed: 9/19/18 - Admission to facility. 9/19/18 - Physicians' orders included the following psychotropic medications: - an antipsychotic and antianxiety (used to treat anxiety) medication for "psychotic disorder with delusions." - an antidepressant medication for "generalized	F 656	F656 (1 & 3) Develop/Implement Comprehensive Care Plan A. Individual/Resident Impacted • The corrective action taken for the resident (R36, R22) found to have been affected by the deficient practice. The comprehensive care plan for R36 and R22 were immediately updated. B. Identification of other residents with the potential to be affected • All residents are at risk to be potentially affected by the deficient practices. C. System Changes • A root cause analysis was completed to determine the cause of the deficient practice.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	085053		C 10/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MOORINGS AT LEWES	17028 CADBURY CIRCLE LEWES, DE 19958

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 21 anxiety disorder." 9/19/18 - The admission MDS assessment documented the resident was at risk for pressure ulcers. 10/17/18 - Review of comprehensive care plan dated 10/10/18 showed: a. no care plan for risk for pressure ulcers due to limited mobility . b. no care plan for the use of the psychotropic medications. c. no care plan identifying how the resident displayed psychotic disorder with delusions. d. no care plan identifying how R36 exhibited anxiety. e. care plan goals for the problem of loneliness and tearful when separated from husband "will have regular visits from my husband" and "participate in activities" were not measurable. f. care plan entered in the EMR after the 21 day time frame. 10/17/18 (9:00 AM) - Interview with E7 (RNAC) when providing the surveyor with a copy of the care plan E7 stated "This one was added in the computer today" and confirmed it was a week late. 10/17/18 (5:16 PM) - Interview with E4 (Clinical Analyst) reviewed the care plan and confirmed targeted behaviors for the psychotropic medications were not included in the care plan. 2. Review of R18's clinical record revealed: 8/27/18 - Admission to facility from Assisted Living due to recent weight loss and poor intake.	F 656	The root cause identified is failure to develop and implement a comprehensive care plan to support the needs of the resident as specified on the CMS regulations secondary to communication failure and lack of processes. • Every admission including the baseline care plan will be reviewed by the Inter-Disciplinary Team (IDC) within 24 to 72 hours after admission to identify potential irregularities and update the care plan as appropriate. • Comprehensive care plans will be initiated by the RNAC upon completion of the five-day MDS assessment. Comprehensive care plans will be completed by day 21. • The Regional Nurse Consultant will conduct an "I" care plan in-service training by 12/7/2018 and then quarterly thereafter. D. Success Evaluation • The DON/Designee will conduct random care plan audits, one chart per week for the next 12 weeks and then 2 charts per month for the next 6 months until 100% compliant for 3 consecutive months. • DON/Designee will be report all care plan audit results monthly at the QAPI committee meeting. Results of audits will be reviewed during QAPI meetings. QAPI Committee will identify trends and make recommendations based on audit results. F656 (2) Develop/Implement Comprehensive Care Plan A. Individual/Resident Impacted	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	085053		C 10/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MOORINGS AT LEWES	17028 CADBURY CIRCLE LEWES, DE 19958

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 22 8/27/18 - Nutrition assessment included both fluid and calorie needs: 1,913-2,295 mL/day fluids, 1,913-2,066 calories/day. 9/10/18 - Progress note documented R18 had decreased appetite and oral intake. R18's current care plan for altered nutrition addressed calorie needs, but not the resident's hydration or fluid needs. 10/22/18 (around 4:40 PM) - Interview with E2 (DON) to review the care plan finding. 3. Review of R22's clinical record revealed: 10/17/18 - Review of comprehensive care plan showed: - Care plan problem "I am on comfort care and will enjoy watching television as well as daily visits from the activity staff" (effective 12/13/17) had a goal that was not measurable: "My wishes will be respected and my autonomy will be maintained while I'm living here". - Care plan problem "I have failure to thrive as exhibited by not wanting to come out of my room or participate in activities" (effective 3/9/18) had a goal that was not measurable: "I will be assisted to identify ways of increasing meaningful relationships by the next review". - Above care plan problems did not include individualized interventions such as R22 has a private pay companion 5 afternoons a week and enjoys music. 10/22/18 1:30 PM - Interview: E29 (Activities Director) confirmed above interventions would be appropriate for R22.	F 656	• The corrective action taken for the resident (R18) found to have been affected by the deficient practice. The comprehensive care plan was immediately updated. B. Identification of other residents with the potential to be affected • A root cause analysis was completed to determine the cause of the deficient practice. The root cause identified is failure to develop and implement a comprehensive care plan to support the needs of the resident as specified on the CMS regulations secondary to communication failure and lack of processes. • All residents are at risk to be potentially affected by the deficient practices. C. System Changes • Every admission including the baseline care plan will be reviewed by the Inter-Disciplinary Team (IDC) within 24 to 72 hours after admission to identify potential irregularities and update the care plan as appropriate. • The Dietician during his/her assessment period will identify areas for nutritional concern, and implement the appropriate intervention which will be included in the resident centered care plan. • The DON/Designee will conduct random care plan audits, one chart per week for the next 12 weeks and then 2 charts per month for the next 6 months to ensure appropriate problems are	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	085053		C 10/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MOORINGS AT LEWES	17028 CADBURY CIRCLE LEWES, DE 19958

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 23 10/22/18 2:00 PM - Interview: E2 (DON) reviewed above care plan issues. 4. Review of R34's clinical record revealed: 9/6/18 - R34 was admitted to the facility for rehabilitation with diagnoses that included mixed anxiety, depressed mood and anxiety disorder. 9/6/18 - Physician's order for the antipsychotic, Seroquel, but no reason for this medication included in the order. 9/12/18 - Physician order indicated that Seroquel was prescribed for anxiety. 10/3/18 - Psychiatry Consultation confirmed diagnoses of depression and anxiety with plan to continue current regimen (Seroquel and an anti-depressant). 10/16/18 - Review of R34's eMAR revealed that staff were monitoring for "behaviors", but did not specify what the behaviors were. 10/17/18 - Review of R34's care plan revealed that R34 did not have care plan that addressed anxiety and the care plan for "I use psychotropic medications for diagnosis of depression" did not include to monitor for behaviors of depression or anxiety. 10/22/18 2:00 PM - Interview with E2 (DON) reviewed the above care plan issues. 5. The following was reviewed in R17's clinical record:	F 656	identified with their corresponding goals that are specific, measurable, attainable, relevant and timely. • The Regional Nurse Consultant will conduct a care plan in-service training by 12/7/2018 and then quarterly thereafter. D. Success Evaluation • The DON/Designee will conduct random care plan audits, one chart per week for the next 12 weeks and then 2 charts per month for the next 6 months to ensure 100% compliance for 3 consecutive months. • DON/Designee will be report all care plan audits monthly at the QAPI committee meeting. Results of audits will be reviewed during QAPI meetings. QAPI Committee will identify trends and make recommendations based on audit results. F656 (4) Develop/Implement Comprehensive Care Plan • Individual/Resident Impacted • The corrective action taken for the resident (R34) found to have been affected by the deficient practice. The comprehensive care plan was immediately updated to include target behaviors and psychotropic drugs. • Identification of other residents with the potential to be affected • A root cause analysis was completed to determine the cause of the deficient practice. The root cause identified is failure to develop and implement a comprehensive care plan to support the needs of the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	085053		C 10/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MOORINGS AT LEWES	17028 CADBURY CIRCLE LEWES, DE 19958

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 24 8/16/18 - Admission to the facility. 10/15/18 9:07 AM - Interview with E28 (CNA) who reported that after R17's stroke, R17 had reverted back to his native Greek language. Can very minimally verbalize in English as well. E28 stated that R17 usually gestures, nods head, and points to make needs known. At times he gets frustrated when trying to communicate. 10/15/18 12:05 PM - Attempted to converse with resident and unable to discern R17's verbalization except the word no, and head shaking to reply yes or no. R17 appeared frustrated and declined to communicate with surveyor. R17 wheeled away in wheelchair. 10/17/18 1:30 PM - Interview with R17's son, who reported that R17 has a communication board but declines to use it. 10/18/18 3:15 PM - Interviews with E28 (CNA), E27 (CNA), and E26 (LPN)) confirmed the resident will not use the communication board but will nod, point, and gesture to make needs known. E27 and E28 reported that R17 is rarely a participant in activities because he becomes frustrated about his communication needs and prefers to spend most of time in his room. Review of R17's care plan lacked evidence that communication was addressed. 6. The following was reviewed in R42's clinical record: 9/24/18 - Admission on Hospice services. Facility Hospice policy includes:	F 656	resident as specified on the CMS regulations secondary to communication failure and lack of processes. • All residents are at risk to be potentially affected by the deficient practices. • System Changes • Every admission including the baseline care plan will be reviewed by the Inter Disciplinary Team (IDC) within 24 to 72 hours after admission to identify potential irregularities and update the care plan as appropriate. • Comprehensive care plans will be initiated by the RNAC upon completion of the five-day MDS assessment. Comprehensive care plans will be completed by day 21. • The DON/Designee will conduct an audit on all residents on psychoactive medication; identify the specific target behavior for each corresponding psychoactive medication. • The Regional Nurse Consultant will conduct a care plan in-service training by 12/7/2018 and then quarterly thereafter. • Success Evaluation • The DON/Designee will conduct random psychoactive medication order audits, one chart per week for the next 12 weeks and then 2 charts per month for the next 6 months until 100% compliance is achieved for 3 consecutive months. • DON/Designee will be report all care plan audits monthly at the QAPI committee meeting. Results of audits will be reviewed during QAPI meetings. QAPI	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	085053		C 10/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MOORINGS AT LEWES	17028 CADBURY CIRCLE LEWES, DE 19958

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 25 A coordinated plan of care between the facility, hospice agency and resident/family will be developed and shall include directives for managing pain and other uncomfortable symptoms. The care plan shall be revised and updated as necessary to reflect the resident's current status. 9/28/18 - R42's Admission MDS documented life expectancy less than 6 months and on Hospice. 10/17/18 12:32 PM - Interview with E7 (RNAC) and E26 (LPN) confirmed that there was no care plan for Hospice. October 2018 eMar Physician's orders included two medications for depression and one for anxiety. 10/17/18 2:36 PM - E7 (RNAC) provided timed and dated care plans to the surveyor which did not include care plans for anxiety or depression. These findings were reviewed during the exit conference on 10/24/18 beginning at 1:00 PM with E1 (NHA), E2 (DON) and E8 (Staff Educator) in person, and E4 (Clinical Analyst), E5 (Regional Nurse Consultant) and E23 (Corporate Administrator) by telephone.	F 656	Committee will identify trends and make recommendations based on audit results. F656 (5) Develop/Implement Comprehensive Care Plan A. Individual/Resident Impacted • The corrective action taken for the resident (R17) found to have been affected by the deficient practice. The comprehensive care plan was immediately updated to include a communication plan. B. Identification of other residents with the potential to be affected • A root cause analysis was completed and it was determined that this was an isolated incident that was unique to this specific resident (R17.) The resident refused all the interventions offered by the team. The root cause identified is failure to develop and implement a comprehensive care plan to support the needs of the resident as specified on the CMS regulations secondary to communication failure and lack of processes. • All residents that have that speak a primary language other than English are at risk to be potentially affected by the deficient practices. C. System Changes • Upon admission the facility will identify	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	085053		C 10/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MOORINGS AT LEWES	17028 CADBURY CIRCLE LEWES, DE 19958

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 26	F 656	the resident's primary language and will document it in the electronic health record as well as the baseline care plan and communicate it to the IDC team. • The facility will utilize a certified translation service telephonically and/or a communication board for communication services. • An in-service training will be conducted to train all staff on the use of the translation services and any necessary equipment. • If the resident declines the use of the translation service and/or communication board, it will be documented in the electronic health record and the family will be notified about the risks of not being able to communicate with the resident. • The Activities Director will conduct an evaluation of the resident's communication preference through the use of the above services, for those residents at risk to ensure their needs are being met and the conversation will be documented during a scheduled resident care plan meeting. D. Success Evaluation • The Activities Director will conduct an audit of resident communication preferences for all residents to ensure 100% compliance. Results of audits will be reviewed during QAPI meetings. QAPI Committee will identify trends and make recommendations based on audit results. F656 (6) Develop/Implement Comprehensive Care Plan	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	085053		C 10/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MOORINGS AT LEWES	17028 CADBURY CIRCLE LEWES, DE 19958

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 27	F 656	A. Individual/Resident Impacted • The corrective action taken for the resident (R42) found to have been affected by the deficient practice. The comprehensive care plan was immediately updated to include a hospice care plan. B. Identification of other residents with the potential to be affected • A root cause analysis was completed to determine the cause of the deficient practice. The root cause identified is failure to develop and implement a comprehensive care plan to support the needs of the resident as specified on the CMS regulations secondary to communication failure and lack of processes. • All residents are at risk to be potentially affected by the deficient practices. C. System Changes • Every admission including the baseline care plan will be reviewed by the Inter-Disciplinary Team (IDC) within 24 to 72 hours after admission to identify potential irregularities and update the care plan as appropriate Comprehensive care plans will be initiated by the RNAC upon completion of the five-day MDS assessment. Comprehensive care plans will be completed by day 21. • All care plans will be dated when initiated and updated. • The Regional Nurse Consultant will conduct an "I" care plan in-service training by 12/7/2018 and then quarterly	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	085053		C 10/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MOORINGS AT LEWES	17028 CADBURY CIRCLE LEWES, DE 19958

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 28	F 656	thereafter. D. Success Evaluation • The DON/Designee will conduct chart audits on all residents that are on hospice service and then 1 chart per month for the next 6 months until 100% compliance is achieved for 3 consecutive months to ensure that hospice residents have the appropriate hospice care plan. • DON/Designee will be report all care plan audits at the monthly QAPI committee meeting. Results of audits will be reviewed during QAPI meetings. QAPI Committee will identify trends and make recommendations based on audit results.	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that for one (R17) out of 34 sampled residents the facility failed to provide facial shaving for a dependent resident. The following findings were revealed in R17's record: 8/16/18- Admission to facility with multiple diagnoses including stroke with right-sided weakness and difficulty speaking. 8/23/18 - Admission MDS revealed that R17	F 677	F677 ADL Care Provided for Dependent Residents A. Individual/Resident Impacted • The corrective action taken for the resident (R17) found to have been affected by the deficient practice. B. Identification of other residents with the potential to be affected • All residents at risk to be potentially affected by the deficient practice. C. System Changes	12/21/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	085053		C 10/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MOORINGS AT LEWES	17028 CADBURY CIRCLE LEWES, DE 19958

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 29 required extensive with one person physical assist for personal hygiene (including shaving) and was severely cognitively impaired. During the following observations R17 was unshaven: 10/15/18 (8:20 AM and 1:40 PM); 10/16/18 (8:00 AM and 2:15 PM); 10/17/18 (8:54 AM and 1:18 PM); 10/18/18 (2:44 PM and 4:05 PM); and 10/19/18 (8:58 AM). 10/17/18 1:18 PM - Interview with R17 and FA1 (R17's son) revealed that the resident did not make a choice to grow a beard. When asked whether R17 would allow staff to shave him, the resident reported yes. FA1 added that R17 did not usually refuse for staff to shave him. 10/18/18 4:05 PM - Interview with E27 (CNA) revealed that R17 needed a shave and shower. 10/18/18 4:10 PM Interview with E28 (CNA), E27 (CNA) and E26 (LPN) revealed the following: E26 stated that R17 would refuse care and swing at staff on occasion. E28 explained that CNAs could not document behaviors and that CNAs tell the nurse about behaviors / refusals of care. E26 reported nurses chart by exception and that behavior documentation was not in their EMR. E26, E27, and E28 reported that R17 had no refusals that week. Staff did report that a family member / friend was supposed to come in to shave R17. E27 said that R17 might let her do it tonight since"he likes her." This finding was reviewed during the exit conference on 10/24/18 beginning at 1:00 PM with E1 (NHA), E2 (DON) and E8 (Staff Educator) in person, and E4 (Clinical Analyst), E5 (Regional Nurse Consultant) and E23 (Corporate	F 677	• The admitting nurse on admission will identify resident preferences for personal care and grooming and document on the baseline care plan; communicate it to the staff during shift endorsement. • The Social Worker will indicate the resident's preferences for personal care and grooming on the social work initial assessment which must be completed within 72 hours. • The in-service coordinator will conduct an all staff in-service training on appropriate documentation and reporting of behaviors and refusal of care to be completed no later than 12/21/2018. D. Success Evaluation • The DON/Designee will conduct random resident checks to ensure residents are properly groomed, 5 residents daily for the next month and then 4 residents monthly for the next 6 months and will be reported at monthly QAPI. (See Attachment 12)	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	085053		C 10/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MOORINGS AT LEWES	17028 CADBURY CIRCLE LEWES, DE 19958

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 30 Administrator) by telephone.	F 677		
F 678 SS=K	Cardio-Pulmonary Resuscitation (CPR) CFR(s): 483.24(a)(3) §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced by: Based on record review, interview and review of other facility documentation as indicated, the facility failed to ensure that advanced directives were accurate and congruent in all facility documents for six (R16, R100, R4, R104, R12 and R39) out of the 37 residents residing in the facility on 10/23/18. R16, R100, R4, R104 and R39 had current physician's orders for full code in the electronic (computer) medical record (EMR), but the DNR Consent Form on the front of their respective paper chart and signed by the resident or their power of attorney, documented they were a DNR. In addition, all five residents had a red sticker on their chart that said "DNR." R12 had a current physician's order for a DNR, but the DNR Consent Form on the front of the chart and signed by R12 and the physician documented the resident was a full code. The code status as recorded in two different documents did not match. This discrepancy put these six (R16, R100, R4, R104, R12 and R39) residents at immediate jeopardy (IJ) of not having a confirmed, accurate code status in the event of a medical emergency. Three (3 of 3 facility nursing staff assigned to direct resident care at the time the IJ was identified, stated they would look in the	F 678	F678: Cardio-Pulmonary Resuscitation A. Individual/Resident Impacted • The corrective action taken for all residents found (R16, R100, R4, R104, R12, and R39) to have been affected by the deficient practice. An audit of all impacted resident charts was immediately conducted to verify that the code status orders were correct. Any discrepancies were immediately corrected. Communication with the physician occurred as appropriate B. Identification of other residents with the potential to be affected • All residents are at risk to be potentially affected by the deficient practices. C. System Changes • An audit of all charts will be conducted on October 23, 2018 to ensure correct code status is transcribed on the electronic health records. Once verified, the correct information about whether or not the elder has executed an advance	10/24/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	085053		C 10/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MOORINGS AT LEWES	17028 CADBURY CIRCLE LEWES, DE 19958

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 678	Continued From page 31 computer (EMR) to find out if they needed to start CPR (cardiopulmonary resuscitation) if a resident coded. Discrepancies between physician's orders and DNR Consent Forms placed these residents in an immediate jeopardy situation. The IJ was identified on 10/23/18 at 1:10 PM and was abated on 10/23/18 at 4:40 PM. Findings include: The facility policy entitled "CPR/AED Code Procedure" (last revised 2/22/12) stated the policy is to provide CPR to all facility residents without a DNR order. The facility policy entitled "Advanced Directives" (last revised 10/30/14) stated that the Director of Nursing Services or designee would notify the Attending Physician of advanced directives so that appropriate orders can be documented in the resident's medical record and plan of care. The facility policy entitled "Advanced Care Planning: Advanced Directives and POLST (Physician's Orders for Life Sustaining Treatment)" (last revised 9/13/17) provided by the facility stated that the Physician/Nurse Practitioner are responsible for the final clarification of treatment preferences and documentation of the appropriate orders on the POLST form. The POLST is not a legal document in the state of Delaware, therefore it cannot be used for physician orders. In addition, no POLST forms were found on the facility charts. 1. Review of R16's clinical record revealed: 10/15/18 1:18 PM - During the initial pool record review, a "DNR Consent Form" was in the front of	F 678	directive shall be displayed prominently in the medical record. (See Attachment 13) • All DNR orders can only be transcribed into the electronic health record as a physician order. • System changes will address root cause of deficiency through staff education and process changes. The in-service director will educate all licensed staff starting immediately and completed within 7 days and during initial orientation for new employees and annually on order reconciliation, verification of orders and 24 hour chart check following Springpoint's policies and procedures. • The Social Worker/designee will audit 5 charts daily times 30 days and 10 charts monthly for the next 6 months to ensure proper transcription of code status for all residents. (See Attachment 14) • The DON/designee will review all new admission orders within 24 hours for a period of 3 months and 5 charts selected randomly weekly for the next 6 months. (see Attachment 13) • To prevent recurrence of the deficient practice, other residents will be identified having the potential to be affected by the same deficient practice through the use of the newly created code status consent form that has been approved by the medical director. This form captures on one page the resident's name and room number, the resident's code status wishes, documentation of who participated in the code status conversation, and the appropriate signatures. • System change process will involve	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	085053		C 10/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MOORINGS AT LEWES	17028 CADBURY CIRCLE LEWES, DE 19958

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 678	Continued From page 32 the chart, signed by R16's POA and a facility nurse on 5/14/18, and signed by the physician on 10/15/18. The signed DNR Consent Form stated R16 is a DNR. A red sticker stating "DNR" was on R16's chart. However, R16's current physician's orders documented R16 is a full code. 10/17/18 3:55 PM - During an interview, both E8 (RN, Educator) and E24 (RN, Charge Nurse) confirmed the physician's order stated R16 was full code, when in fact the resident should be a DNR. E8 then corrected this order and confirmed that facility policy is unless the physician orders state otherwise a resident is a full code. 2. Review of R39's clinical record revealed: 10/16/18 10:02 AM - During the initial pool record review, a "DNR Consent Form" was in the front of the chart, signed by R39 and a facility nurse on 9/25/18, and signed by the physician on 9/26/18. The signed DNR Consent Form stated R39 is a DNR. A red sticker stating "DNR" was on R39's chart. However, R39's current physician's orders documented R39 as a full code. 10/23/18 8:40 AM - Interview with E25 (Social Worker) revealed that the E25 is no longer responsible for entering resident's code status into the computer, and does not know who now has this responsibility. E25 stated that the EMR chart is the most current and reflective of resident's wishes. 10/23/18 11:22 AM - During an interview, E9 (Charge RN) stated advance directives should be in both the EMR and the paper chart. E9 thought they were waiting for the physician to sign R39's DNR. When informed that the "DNR Consent	F 678	reconstructing the DNR consent form to a code status consent form. • All nursing staff will be in-serviced by November 30 with documentation of in-service training on the code status consent form. (See Attachment 13) D. Success Evaluation • Audits will be conducted by the RNAC on all new admission residents and with each quarterly, annual, and significant change assessments until 100% compliance is achieved and maintained for one quarter and then random auditing of up to 10 residents quarterly for all new admissions. • The results of the audits of code status will be reviewed at the monthly QAPI meeting up until the next annual survey to ensure compliance and accuracy.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	085053		C 10/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MOORINGS AT LEWES	17028 CADBURY CIRCLE LEWES, DE 19958

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 678	Continued From page 33 Form" has been signed by the physician, E9 stated there are checklists that are done when a resident is admitted to verify orders are correct, and the night shift is supposed to do chart checks. E9 confirmed that R39 is a DNR and that "this one must have been missed." 3. Review of R100's clinical record revealed: 10/23/18 11:25 AM - During a record review, the "DNR Consent Form" was in the front of chart, signed by R100's POA on 10/10/18 and signed by the physician on 10/15/18. The signed DNR form stated R100 is a DNR. A red sticker stating "DNR" was on the chart. However, R100's physician order documented that the resident is a full code. 10/23/18 3:10 PM - Interview with E2 (DON) confirmed the physician's order erroneously stated R100 was a full code, when in fact the resident was a DNR. E2 stated that this order has been corrected. 4. Review of R4's clinical record revealed: 10/23/18 11:28 AM - During a record review, the "DNR Consent Form" was in the front of chart, signed by R4's POA and a facility nurse on 3/13/18. The signed DNR form stated that R4 is a DNR. A red sticker stating "DNR" was on the chart. However, R4's physician order documented that the resident is a full code. 10/23/18 3:10 PM - Interview with E2 (DON) confirmed the physician's order erroneously stated R4 was a full code, when in fact the resident was a DNR. E2 stated that this order has been corrected.	F 678		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	085053		C 10/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MOORINGS AT LEWES	17028 CADBURY CIRCLE LEWES, DE 19958

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 678	Continued From page 34 5. Review of R104's clinical record revealed: 10/23/18 11:29 AM - During a record review, the "DNR Consent Form" was in the front of the chart, signed by R104's POA and a facility nurse on 10/15/18 and signed by the physician on 10/18/18. The signed DNR form stated that R104 is a DNR. A red sticker stating "DNR" was on the chart. However, R104's physician order documented that the resident is a full code. 10/23/18 3:10 PM - Interview with E2 (DON) confirmed the physician's order erroneously stated R104 was a full code, when in fact the resident was a DNR. E2 stated that this order has been corrected. 6. Review of R12's clinical record revealed: 10/23/18 11:30 AM - During a record review, the "DNR Consent Form" was in the front of the chart, signed by R12 and a facility nurse on 7/24/18 and signed by the physician on 7/26/18. The signed DNR form stated that R12 is a full code. However, R12's EMR header documented that the resident is a DNR. 10/23/18 3:10 PM - Interview with E2 (DON) confirmed that R12's EMR header documented the resident as a DNR, when in fact R12 was a full code. E2 stated that this order has been corrected. 10/23/18 11:20 AM - 11:36 AM: Interviews with 3 of 3 facility nurses (E9, E11 and E12) assigned to direct resident care at the time the IJ was identified, stated they would look in the computer (EMR) to find out if they needed to start CPR	F 678		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	085053		C 10/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MOORINGS AT LEWES	17028 CADBURY CIRCLE LEWES, DE 19958

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 678	Continued From page 35 (cardiopulmonary resuscitation) if a resident coded. 10/23/18 12:20 PM - During an interview, E9 (RN, Charge Nurse) was asked to demonstrate how to enter Advance Directives in the EMR so that "DNR" appeared next to the resident's name. E9 entered the code status for R39 under the Advance Directive section of the EMR, but the DNR did not appear on the screen. Around 12:30 PM E4 (Clinical Analyst) joined in the demonstration and stated that the only way for the DNR indication to appear was to enter the code status as an order. E9 stated that s/he had been "doing it wrong." 10/23/18 12:45 PM - During an interview with E1 (NHA), E2 (DON), E8 (RN, Educator), E4 (Clinical Analyst), and E5 (Regional Nurse Consultant), E5 confirmed that the facility policy is that all residents are a full code unless there is an order in the EMR stating otherwise (e.g., a physician's order for DNR). The survey team explained and identified the six current residents that had conflicting advance directives (code status) and physician's orders in the medical record. Physician orders did not match resident and/or POA signed DNR Consent Forms. The survey team requested the facility to: 1. Immediately conduct an audit of every current residents' chart to verify that code status orders are correct and provide the survey team with a copy of the results. 2. Confirm and correct any discrepancies found. 3. Established the practice of where nursing staff finds code status and enters orders into the EMR. 4. Review current policies and revise as needed to reflect this practice and to prevent reoccurrence.	F 678		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	085053		C 10/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MOORINGS AT LEWES	17028 CADBURY CIRCLE LEWES, DE 19958

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 678	Continued From page 36 5. Provide a plan of correction, including staff education. 10/23/18 1:10 PM - E2 (DON), E8 (RN, Educator), E4 (Clinical Analyst), and E5 (Regional Nurse Consultant) were notified by the survey team that an IJ was identified when six current residents reviewed were found to have inconsistent advance directives related to their code status in the medical records. 10/23/18 3:10 PM - E2 (DON) provided the survey team with a copy of the audit results, confirmed that the errors identified by the survey team were corrected and that no additional discrepancies were found. 10/23/18 4:05 PM - During an interview with E1 (NHA), E2 (DON), E8 (RN, Educator), E4 (Clinical Analyst), and E5 (Regional Nurse Consultant), the survey team was provided with a written plan of correction that was being implemented, a revised policy, a plan for nursing staff education and a plan for future auditing. 10/23/18 4:35 PM - E8 provided the survey team with a copy of the content of the nursing staff education. 10/23/18 4:40 PM - The IJ was abated. The facility failed to ensure that: -Advanced directives/code status for all residents were accurate and congruent in all facility documents. -Facility nurses would be able to locate an accurate and current physician order rgarding DNR status when it was needed in an emergent situation.	F 678		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	085053		C 10/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MOORINGS AT LEWES	17028 CADBURY CIRCLE LEWES, DE 19958

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 678	Continued From page 37 This finding was reviewed during the exit conference on 10/24/18 beginning at 1:00 PM with E1 (NHA), E2 (DON) and E8 (Staff Educator) in person, and E4 (Clinical Analyst), E5 (Regional Nurse Consultant) and E23 (Corporate Administrator) by telephone.	F 678		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive 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 record review, observation and interview it was determined that the facility failed to provide care and services in accordance with professional standards of practice for two (R18, and R34) out of 35 sampled residents. For R18, the facility failed to follow facility standard of practice and care plan for a resident with a fever and UTI by ordering fluids at designated intervals, monitoring intake and output and documenting nursing assessment findings. For R34, the facility failed to implement the bowel protocol. Findings include: 1. Review of R18's clinical record revealed: 8/27/18 - Admission after experiencing weight loss in an assisted living facility.	F 684	F684 (1): Quality of Care A. Individual/Resident Impacted • The corrective action taken for resident (R18) found to have been affected by the deficient practice. The resident expired on 10/30/2018. B. Identification of other residents with the potential to be affected • All residents are at risk to be potentially affected by the deficient practices. C. System Changes • Root cause was completed to determine the cause of the deficient practice. The root causes are as	12/31/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	085053		C 10/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MOORINGS AT LEWES	17028 CADBURY CIRCLE LEWES, DE 19958

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 38 8/27/18 - Admission MDS Assessment documented the resident had moderate cognitive impairment and was independent with 1 person assist for eating. Always incontinent of urine, but continent of bowel. 8/27/18 Nutrition assessment - Resident stated usual weight 180s but had significant weight loss over the past month in assisted living. Current weight 168.4 pounds. Chocolate Boost supplement 120 mL four times a day, continue weekly weights. Needs 1,913-2,295 mL/day fluids, 1,913-2,066 calories daily. 8/27/18 - Care plan for nutrition included the goal to eat at least 75% estimated calories. Current active care plan for incontinence included intervention to record R18's output each shift. 9/10/18 - Progress note documented R18 was confused, some agitation, decreased appetite . . . incontinence worsening. . decreased oral intake. 10/4/18 Nutrition note - Weight 162 pounds (weight without ankle boot). Ate in dining room and often seen staring at food and not eating. Did not initiate eating well when encouraged. Discussed with MD. Oral intake averaging 35% over past 3 days and eMAR shows accepting health shake at dinner and around 520 mL of a liquid supplement (Boost) daily for around 75% of calorie needs. Add health shake at lunch. 10/11/18 - Nursing note documented a note was left for the physician / NP about R18's appetite decreasing for past 3-4 days. Labs 10/12/18 - Lab tests show kidney function	F 684	identified: The Dietitian and Nursing Team failed to implement professional standards of practice and follow facility standards of practice as specified on the Springpoint policies and procedures secondary to lack of training and conflicting information. • The dietitian conducted a record review back to August 1, 2018 to determine if there were residents identified that had hydration concerns. Residents identified for any hydration concerns will be re-evaluated and interventions will be updated as applicable following the current policy and procedure. • Every admission including the baseline care plan will be reviewed by the Inter-Disciplinary Team (IDC) within 24 to 72 hours after admission to identify potential irregularities and update the care plan as appropriate. • The Regional Nurse Consultant/Designee will re-educate the Dietitian on the procedure for addressing residents that have hydration concerns as identified on the current policy and procedure. • The Dietician during his/her assessment period will identify areas for nutritional and/or hydration concerns, and implement the appropriate intervention that will be addressed in the resident centered care plan. • The Resident Hydration and Prevention of dehydration policy has been revised on 11/20/2018 to reflect changes to the process addressing hydration issues. • The Dietician/Designee will conduct	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	085053		C 10/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MOORINGS AT LEWES	17028 CADBURY CIRCLE LEWES, DE 19958

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 39 compromised with elevated BUN 24 (normal 7 - 17) and creatinine 1.5 (normal 0.52 - 1.04) and sign of infection with elevated WBC 15.5 (normal 3.7 - 8.9). 10/13/18 - Resident complained of nausea with dry heaves at dinner. Temperature (T) 100.7 F. NP ordered urine culture and started an antibiotic to be injected in the muscle (Rocephin) daily for 5 days. Facility policy entitled Resident Hydration and Prevention of Dehydration (last revised 3/10/13) included that orders may be written for extra fluids to be encouraged between meals and / or with medication passes. A specific minimum amount should be included in the order (e.g. 240 mL fluids twice a day with medication pass). "Force fluids is not an appropriate order." "Encourage fluids" is not an adequate order. . . Resident who routinely should be on I&O monitoring are residents: . . with urinary tract infection (UTI) . . with physicians orders for fluids restrictions or orders to encourage fluids; with specific orders for additional liquids; who are known to be dehydrated or who are at risk for dehydration. . . . with fever . . . 10/15/18 - Progress note by MD acknowledged kidney labs from 10/12 and wrote diagnoses of urinary tract infection (UTI). . . early sepsis (infection in the blood). There was no mention or order to add oral fluids or to monitor I&O. 10/15/18 - Care plan for urinary tract infection included the interventions to "encourage fluids" cue / assist to drink with, and between meals; and monitor for burning / painful urination.	F 684	an in-service training by 12/21/2018 for all staff on the hydration policy and proper documentation. • The DON/Designee will conduct an in-service training by 12/21/2018 and during monthly meetings for all staff on how to address the resident's needs and to ensure the residents have what they need within reach. • Antibiotic orders will be faxed to the Consultant Pharmacist with associated lab results to be reviewed for appropriate use. • A Respiratory Therapist will conduct an in-service training by 12/21/2018 on how to identify and document respiratory issues to be communicated to the physician. D. Success Evaluation • The Dietician/Designee will conduct a review of nutrition and hydration needs for all residents on admission and then review on a quarterly basis with random auditing of 10 residents per month to ensure 100% compliance. • The DON/Designee will conduct random care plan audits, one chart per week for the next 12 weeks and then 2 charts per month for the next 6 months to ensure that specific residents identified with hydration concerns will addressed until 100% compliance. • Results of audits will be reviewed during QAPI meetings. QAPI committee will identify trends and make recommendations based on audit results. F684 (2): Quality of Care	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	085053		C 10/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MOORINGS AT LEWES	17028 CADBURY CIRCLE LEWES, DE 19958

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 40 According to facility policy, "encourage fluids" was not an adequate intervention. 10/15/18 (around 12:20 PM) - Observed resident in dining room at lunch time, not eating much and staring into space. Resident lips noted to be dry. CNA documentation recorded 25% intake for lunch. Review of infection control surveillance data revealed R18 had frequent antibiotics for infections both in the assisted living and skilled sections of the facility: 2/21/18 (Keflex for UTI); 8/4/18 (Bactrim for UTI); 10/2/18 (Azithromycin for respiratory symptoms); 10/13/18 (Rocephin, then Macrobid on 10/15/18). 10/16/18 - 10/17/18 Observation - Resident remained in bed all day and did not get up. 10/18/18 (7:50 AM - 10:43 AM) - Continuous observation of R18 lying in bed with eyes closed. Facial color appeared reddened. R18 woken up around 9:30 AM for morning medications. Overbed table against the wall at the foot of the bed with a water cup on the table, out of reach of the resident. 10/18/18 (10:43 AM) - Surveyor observed R18 with fast respirations (40 breaths per minute) and informed E2 (DON) who, along with E12 (LPN), assessed R18 at 10:45 AM. R18 responded to voice, T100.4 F, oxygen level in the blood normal for this resident with history of chronic lung disease at 96%, lungs clear per DON. Tylenol given for fever. MD due in later today. E12 stated that R18 was receiving Macrobid for a UTI and that resident drank 340 mL between morning medications and breakfast tray.	F 684	A. Individual/Resident Impacted • The corrective action taken for resident (R34) found to have been affected by the deficient practice. The resident identified had a bowel movement on 10/16/18. B. Identification of other residents with the potential to be affected • All residents are at risk to be potentially affected by the deficient practices. C. System Changes • Root cause was completed to determine the cause of the deficient practice. The root causes are as identified: The nursing team failed to implement professional standards of practice and follow facility standards of practice as specified on the Springpoint policies and procedures secondary to lack of training and poor follow through. • During morning meeting, the Unit Manager/Designee will identify those residents that have not had any bowel movements in the last 72 hours and identify the next steps within the bowel protocol, the interventions completed and the outcome post-intervention. The information will be endorsed to the next shift and forward until such time a response has been met. • The DON/Designee will conduct an in-service training by 12/21/2018 and during monthly meetings for all staff on how to address the resident's needs and to ensure the residents have what they	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	085053		C 10/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MOORINGS AT LEWES	17028 CADBURY CIRCLE LEWES, DE 19958

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 41 10/18/18 (11:00 AM) - Surveyor informed E2 (DON) that urine culture results showed Macrobid was 32 and a different antibiotic was a 1, which was more effective against the bacteria. 10/18/18 (1:10 PM) - Interview with E12 (LPN) who stated the resident had some fluids....Boost, a little water, and cranberry juice. The LPN (E12) added that R18 did not like water. 10/18/18 (2:30 PM) - Interview with E16 (CNA) revealed the resident refused breakfast and lunch but drank 240 mL from each tray. CNA stated it was unusual for the resident to not get up out of bed. Review of CNA documentation found the amount of fluid R18 drank from the meal trays was not recorded in the record. Review of eMAR showed the resident drank 120 mL of Boost at 9:00 AM and 1:00 PM and 120 mL of health shake at noon. 10/18/18 (3:10 PM) - During an interview with E10 (physician) the doctor stated "I don't think that it is from a UTI. She's had several days of Macrobid and still has a temperature. She might have some pneumonia I'm getting an X-ray and labs." Physician ordered Levaquin (antibiotic) to be given once a day by mouth for 10 days. 10/18/18 - MD Progress note documented febrile illness despite 3 days of antibiotic for UTI. Denies pain with urination, but has cough. Plan to check chest x-ray STAT. UTI versus bacteremia (infection in the blood) - no symptoms, will stop Macrobid and start Levaquin,	F 684	need within reach. D. Success Evaluation • The Unit Manager/Designee will conduct random audits (2 residents per day) on Certified Nursing Assistant documentation to ensure complete and accurate documentation of bowel movements. • Unit Manager/Designee will complete the audits monthly x 4 months to ensure that a resident who has not had a bowel movement in the past 72 hours will have completed the bowel protocol as ordered by the physician until 100% compliance is achieved. • The results will be reviewed during the QAPI meetings. QAPI committee will identify trends and make recommendations based on audit results.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	085053		C 10/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MOORINGS AT LEWES	17028 CADBURY CIRCLE LEWES, DE 19958

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 42 a different antibiotic Increased WBCs, will recheck (labs ordered for 10/19). 10/19/18 - Review of the EMR found the nursing assessment from the day prior was not be recorded in R18's record. 10/19/18 (7:52 AM) - Observation of resident in bed with HOB elevated around 30-degrees. R18 was breathing fast at 42 breaths per minute. Oxygen at 1.5 - 2 liters/minute (L) with nasal cannula with prongs along right cheek instead of in the nose. E57 (LPN) entered room to obtain vital signs and place a nebulizer machine at the bedside to provide medication for the resident to breath into the lungs (x-ray showed deflated air sacs in the lower part of the right lung but no pneumonia). Temperature and oxygen level normal E57 positioned nasal cannula correctly on resident. 10/19/18 (around 8:20 AM) - Observed E12 (LPN) talk with the doctor on the telephone about R18. E12 confirmed the resident received a dose of Levaquin the night prior and was not sure if the blood test was done this morning. Nurse informed the physician that resident was put on oxygen last night since she had slight wheezing. 10/19/18 (9:46 AM) - Nursing progress note documented lungs diminished in bases, oxygen at 1.5 L, had nebulizer treatment, on Levaquin. 10/19/18 observation at 10:15 AM resident with eyes now open, looking out window. Overbed table across bed with a water cup and glass of ginger ale. 10/19/18 (around 11:05 AM and again around	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	085053		C 10/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MOORINGS AT LEWES	17028 CADBURY CIRCLE LEWES, DE 19958

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 43 11:50 AM) - Interview with E9 (LPN) revealed no lab results received yet and that they should be here soon. 10/19/18 (around 1:00 PM) - Interview with E56 (CNA) revealed R18 did not drink any of the ginger ale. When asked about R18's urinary output, E56 said R18 "had a little bit of urine" and it "was dark." The CNA added that the resident was "not like this yesterday." R18 "seemed worse today, not responding much." 10/19/18 (around 130 PM) - Interview with E9 (LPN) revealed the lab never sent the blood test results. "I had to call for them." 10/19/18 (4:00 PM) - R18 sent 911 to hospital for infection (blood test showed WBC higher at 26.5) not responding to antibiotics. 10/19/18 - Review of hospital history and physical revealed resident complained of urinary frequency and mild left flank (kidney) pain and diagnosis of acute pyelonephritis (kidney infection that commonly begins in the bladder and moves upstream to one or both of the kidneys). www.niddk.nih.gov > Health Information > Urologic Diseases 10/21/18 - Kidney consultation documented the resident's "oral mucosa was dry, a lower blood pressure than normal and received intravenous fluids and urinary output was becoming marginal but kidney function not improving." No history of kidney disease and urine culture negative which maybe due to receiving antibiotics at nursing facility. The facility failed to monitor R18's output per the	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	085053		C 10/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MOORINGS AT LEWES	17028 CADBURY CIRCLE LEWES, DE 19958

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 44 care plan. The facility also failed to monitor intake and output, as per facility policy, when R18 had a UTI and was receiving antibiotics. The facility did not obtain an order for a specific amount of fluids to be given at designated times since "encourage fluids" was an inadequate order. 2. Review of R34's clinical record revealed: 9/6/18: R34 was admitted to the facility for rehabilitation, with physician orders for the following bowel protocol (medications given for constipation): - Milk of Magnesia (MOM) at bedtime as needed if no bowel movement in 3 days or resident complains of discomfort. - Rectal suppository at bedtime as necessary if no bowel movement on 4th day after milk of magnesia. - Enema rectally as needed if no bowel movement within 12 hours of rectal suppository. If no results call medical doctor. - Senna-S two tablets [medicine for constipation] to be given daily. 9/6/18 - 10/16/18: Review of R34's Medication Administration Records (MARs) and CNA documentation for bowel movements found three times when the bowel protocol orders were not implemented appropriately resulting in constipation: - 9/10/18: No bowel movement since admission (4 days). - 9/16/18: No bowel movement since 9/12/18 (4 days). - 10/13/18: MOM given on 10/12/18, but no bowel movement for next 3 days, no suppository or enema given.	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	085053		C 10/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MOORINGS AT LEWES	17028 CADBURY CIRCLE LEWES, DE 19958

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 45 10/22/18 4:13 PM - During an interview with E2 (DON), the above information was reviewed and the surveyor requested that facility provided additional documentation of bowel movements if available, but no additional information was provided.	F 684		
F 686 SS=G	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 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: Cross Refer F656, Example 1 Based on record review, observation and interview it was determined that the facility failed to provide the care and services to prevent the development of pressure injury/ulcer for one (R36) out of 35 sampled residents. The facility did not complete a Braden Scale on R36's 9/19/18 admission to assess the risk for development of pressure ulcers and did not follow physician orders to offload (raise) heels off the mattress. These failures resulted in harm when R36 developed two pressure ulcers (Unstageable to right heel and DTI to left heel). Findings	F 686	F686: Treatment or Services to Prevent Heel Pressure Ulcer A. Individual/Resident Impacted " The corrective action taken for resident (R36) found to have been affected by the deficient practice. The action was unable to be corrected because the resident (R36) has sustained the pressure ulcers to bilateral heels. Currently, the resident continues to be followed by the Wound Nurse Consultant and has bilateral heels improved, the left heel has epithelialized and the right heel	12/27/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	085053		C 10/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MOORINGS AT LEWES	17028 CADBURY CIRCLE LEWES, DE 19958

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 46 include: The facility policy entitled General Guidelines Wound and Skin Care (last revised 5/4/18) included: - All residents will be assessed by the nurse for risk of skin breakdown using the Braden Scale on admission, readmission, upon major change in condition and quarterly thereafter; - The interdisciplinary plan of care will address problems, goals and interventions directed toward the prevention and/or treatment of impaired skin integrity/pressure ulcer and pain management if appropriate. The facility policy entitled Wound and Skin Care, At Risk Residents (last revised 11/23/12) included the definition of the high risk resident as those scoring 16 or less on the Braden Risk Assessment; Impaired/decreased mobility. . .Cognitive impairment. . .Residents at risk will have. .skin prep (to heels) every shift. . . Heels are extremely vulnerable and must be elevated completely off of bed surface. Utilize pillows, foot splints or heel risers. (The facility policy differs from the Braden Scale definition which lists high risk as a score of 12 or less.) Review of R36's clinical record revealed: 9/13/18 - Admission from Assisted Living (AL) with weakness and fever. 9/14/18 - The Braden Scale score of 15 determined that R36 was at risk for pressure ulcer development. 9/17/18 - Discharge back to AL.	F 686	has decreased in size and in healing stages. B. Identification of other residents with the potential to be affected " All residents are at risk to be potentially affected by the deficient practices. C. System Changes " A root cause analysis was completed which determined that the cause of the deficient practice was failure to follow the Wound and Skin Care Policy and Procedure. " When an admission assessment has been completed by the admitting nurse the Nursing Supervisor/Designee on the next shift will complete the 24-hour admission checklist to ensure that all appropriate orders and assessments have been transcribed onto the electronic health record. " The wound and skin care policy and procedure was revised 11/20/2018 to reflect the changes on the scoring risk. " An in-service will be conducted by the DON/Designee on the admission process, completing the 24hour admission checklist and the Braden Scale, and skin assessment (documentation, schedule, and transcription on the EHR). All residents that have been discharged to a different level of care and have returned to the Skilled Unit greater than 24 hours will be considered a new admission and will follow the entire process for a new admission. " Skin assessments will be conducted	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	085053		C 10/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MOORINGS AT LEWES	17028 CADBURY CIRCLE LEWES, DE 19958

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 47 9/19/18 - Admission after a fall. 9/19/18 (8:53 PM) - An admission note documented R36 was received at 4:00 PM with swelling to the feet, and was alert and confused. The New Wound Alert form completed on admission reflected scattered bruising to the arms and legs, and redness to the perineal/groin region. There were no other areas identified with redness or pressure injury. There was no evidence the facility completed an admission assessment on 9/19/18. Instead the previous admission assessment from 9/13/18 was in the electronic record. There was no evidence that R36 was assessed or had a Braden Scale completed upon admission to the facility on 9/19/18. 9/19/18 - The baseline care plan included interventions to elevate the heels when in bed, weekly skin assessments and skin prep to heels twice a day. It was unclear when skin concern entries were added as individual entries were undated. 9/19/18 - The admission MDS assessment documented R36 had moderate cognitive impairment, required extensive assistance (resident involved in activity, staff provide weight-bearing support) of one staff for bed mobility, was at risk for developing pressure ulcers and had no pressure ulcers. 9/20/18 - A physician's order included hip/pelvis CT scan due to resident having hip pain (scheduled for 9/24/18). 9/21/18 - Physicians' orders included skin prep	F 686	weekly and documented on the treatment section and signed off on the electronic health record. " The nurses will ensure physician orders are correctly written and transcribed when performing 24-hour chart checks. " An in-service will be conducted by the DON/Designee on the CNA documentation specifically identifying the documentation for preventive measures for residents who are a risk for skin impairment, appropriate positioning and application of heel lifts, pillow, and boosts, and resident refusals of interventions. " On a weekly basis, the interdisciplinary team will meet to discuss resident who are high risk for skin impairment, residents who currently have pressure ulcers, evaluate all the interventions for appropriateness, and discuss the weekly wound report conducted by the Wound Nurse Consultant. D. Success Evaluation " The DON/Designee will conduct chart audits, one chart per week for the next 12 weeks and then 2 charts per month for the next 6 months until 100% compliance has been achieved for 3 consecutive months to ensure that all physician orders are correctly written and transcribed. " Audits conducted by DON/Designee will be reported to the monthly to the QAPI committee. Results of audits will be reviewed during QAPI meetings. QAPI Committee will identify trends and make recommendations based on audit results.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	085053		C 10/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MOORINGS AT LEWES	17028 CADBURY CIRCLE LEWES, DE 19958

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 48 twice a day. However, there was no application site listed. 9/24/18 - The CT scan revealed R36 had a broken pelvis. The physician ordered PRN pain medication. 9/26/18 - A Braden Scale revealed R36 remained at risk for developing pressure ulcers. 9/27/18 - A skin integrity note documented R36 had no pressure ulcers. 10/6/18 (12:28 PM) - A skin integrity note stated "dark colored blister noted to right heel" measuring 3 cm x 5 cm with clear drainage. R36 was not noted to have pain or discomfort. 10/6/18 - A physician's order directed to elevate both heels from bed. 10/9/18 - Wound assessment by a NP consultant described the heels: - Left: 4 cm x 4 cm purple discoloration, skin intact, DTI (deep tissue injury). - Right: 4 cm x 4.5 cm purple, yellow, red discoloration, open with moderate drainage,unstageable. 10/9/18 - Physician orders included skin prep twice a day [to heels] and apply [name of dressing] every 2 days. 10/10/18 - A care plan for new areas to bilateral heels, included the following interventions: Skin prep to left heel. Once right heel resolved then skin prep both heels. Encourage/assist with repositioning as needed. Float heels (elevate) when in bed. Weekly wound rounds with	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	085053		C 10/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MOORINGS AT LEWES	17028 CADBURY CIRCLE LEWES, DE 19958

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPRQPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 49 measurements, description and documentation of findings. Assess effectiveness of treatment every 2 weeks. Check skin with each care contact and report redness immediately. 10/1/18 - 10/16/18 - Review of CNA documentation for preventative measures revealed 19 out of 48 shifts without documented evidence of offloading heels ("None" was documented indicating no preventative measures were completed during the shift, or the entry was blank) both before and after the development of the two pressure ulcers as follows: - Before the development of the pressure ulcer on 10/6/18: Night shifts: October 1, 2, 3, 4 Evening shifts: 0 Day shifts: October 4. - After the development of the pressure ulcer on 10/6/18: Night shifts: October 6, 7, 9, 10, 13, and 14 Evening shifts: October 6, 8, 11, 12 and 15 Day shifts: October 13, 14 and 16. 10/17/18 (2:35 PM) - During observation of wound care by E12 (LPN) the right heel had a superficial circular open area with black tissue along the bottom of the heel in a semi-circular pattern. The left heel looked like a blister had reabsorbed and the skin was intact. R36, with eyes closed, had no facial expression of pain during the wound care observation. A black wedge cushion was positioned under R36's ankles to elevate the heels off the bed. E12 stated that the facility had a bunch of the wedge pillows. During a follow-up interview at 4:25 PM, E12 confirmed R36 had been using the wedge cushion for about a week (making it approximately since 10/10/18).	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	085053		C 10/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MOORINGS AT LEWES	17028 CADBURY CIRCLE LEWES, DE 19958

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 50 10/17/18 (4:33 PM) - Interview with E14 (CNA) revealed that when the resident was admitted, he/she had nothing wrong with his/her feet. When asked how R36's feet were offloaded, the CNA stated "with pillows." When asked how compliant was R36 with placement of the pillows for offloading, E14 said he/she "would leave them" (not kick them out). 10/17/18 (4:35 PM) - Interview with E13 (CNA) determined that R36 "got them here" when referring to the heel pressure ulcers. 10/18/18 (8:15 AM) - R36 was observed in bed lying on his/her back with a foot cradle in place to raise the bed linens off the feet. R36 had a single bed pillow under the calves and knees with the heels directly on the mattress. 10/18/18 (around 3:50 PM) - During an interview with E4 (Clinical Analyst) it was confirmed there was no admission assessment with the Braden Scale completed on 9/19/18. 10/19/18 (around 7:15 AM) - R36 was observed in bed, slightly turned to the left, with a bed pillow beneath the legs but both heels were in contact with the mattress. 10/19/18 (around 7:30 AM) - Interview with E12 (LPN) confirmed that R36's heels had been touching the mattress during the 7:15 AM observation. The LPN stated she saw the surveyor leave the room earlier and readjusted the pillow to elevate the heels off the mattress. The facility failed to: - assess R36's Braden Scale on 9/19/18 as	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	085053		C 10/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MOORINGS AT LEWES	17028 CADBURY CIRCLE LEWES, DE 19958

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 51 required on admission. - offload heels, as per physician order for 19 out of 48 shifts in October, 2018. - provide care, consistent with professional standards of practice, to prevent the development of pressure ulcers. These failures resulted in harm when R36 developed two pressure ulcers (unstageable on right heel and DTI on left heel). 10/22/18 (around 4:40 PM) - Findings were reviewed with E2 (DON). Findings were reviewed during the exit conference on 10/24/18 beginning at 1:00 PM with E1 (NHA), E2 and E8 (Staff Educator) in person, and E4, E5 (Regional Nurse Consultant) and E23 (Corporate Administrator) by telephone.	F 686		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with	F 688		12/31/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	085053		C 10/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MOORINGS AT LEWES	17028 CADBURY CIRCLE LEWES, DE 19958

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 52 the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and interview it was determined that the facility failed to provide care and services to promote mobility for two (R42 and R19) out of 35 sampled residents. R42 did not have a properly-sized wheelchair and R19 was not ambulated according to the care plan. Findings include: 1. Review of R42's clinical record revealed: 9/24/18 - Admission to facility. 10/1/18 - Admission MDS assessment documented R42 as non-ambulatory requiring extensive assist of one person for wheelchair mobility. 10/18/18 1:30 PM - Interview with E44 (Therapy Director) regarding R42's wheelchair height. E44 reported that the resident had a smaller chair that was rented when R46 was in Assisted Living prior to going to the Hospital and moving upstairs to the skilled unit. E44 stated she had not received a therapy screen for R42 regarding the height of wheelchair, but therapy was aware of the wheelchair being too high. E44 thought there was a call out to the family to see if they had R42's smaller wheelchair. Since R42 was on Hospice the Therapy Director stated that Hospice should provide an appropriate size chair. 10/18/18 1:35 PM - R42 was observed in the wheelchair in front of nurses station with legs dangling from wheelchair about six inches from the ground and no footrests provided.	F 688	F688 (1): Increase/Prevent Decrease in ROM/Mobility A. Individual/Resident Impacted • The corrective action taken for resident R42 found to have been affected by the deficient practice. Therapy assessed the resident to determine the correct height; the wheelchair was ordered and given to the resident. B. Identification of other residents with the potential to be affected • All residents are at risk to be potentially affected by the deficient practices. C. System Changes • Root cause analysis was completed to determine the cause of the deficient practice. The root cause identified: The staff failed to communicate to the therapy department that the resident needed a chair to fit the size and needs of the resident (R42). • Therapy will identify other residents who have the potential to be affected by the same deficient practice by auditing all residents for appropriate wheel chair heights based on correct positing in the chair. For new admissions, the therapy department performs their initial evaluations or screens and obtains at that time the correct height wheel chair for the specific resident. If any resident (new admission/skilled/LTC) is found to be in an	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	085053		C 10/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MOORINGS AT LEWES	17028 CADBURY CIRCLE LEWES, DE 19958

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 53 10/18/18 1:40 PM - Interview with E11 (LPN) who stated that [name of company] picked up the rented chair and that Hospice gave R42 her current chair. 10/18/18 3:28 PM - Interview with E44 (Therapy Director) who stated that R42 was ordered a smaller chair. E44 reported that nursing was taking care of getting R42 the smaller chair. 10/19/18 2:30 PM - R42 was observed in a smaller, lower wheelchair and the resident's feet being closer to the ground. The smaller chair was provided to R42 after the surveyor informed facility staff of the resident's concern about the height of the chair. 10/22/18 9:34 AM - Interview with E42 (Therapy Director) who reported that the new chair was still too high and R42 still could not touch the ground with his/her feet. Surveyor observed there were about 2 inches between the resident's feet and the floor and no foot rests provided. 2. Review of R19's clinical record revealed: 6/19/18 - Care plan stated: "I require an ambulation program, I am at risk for falls related to weakness and altered mobility, manage pain; The goal is "I will participate and meet the goals of my ambulation program over the next review period" with the goal date listed as being 12/4/18. Included in interventions is the following: "Ambulation program as specified: walk with right knee brace with rolling walker, gait belt, close wheelchair to follow and assist of two twice a day 50 - 75 feet as tolerated".	F 688	inappropriate height chair, the therapy department will notify the nursing department so that the correct size wheel chair can be ordered for the resident if one is not available through the therapy department. • An initial audit will be conducted for all residents from August 1, 2018 to determine if there are residents identified that had required the use of a wheelchair are using a wheelchair of appropriate height, size and style. • All staff will be in-serviced by 12/21/2018 on the Therapy Referral Program, "Therapy Referral from Someone Who Cares" by the therapy director to discuss the process of communication in referring a resident to therapy through this program. • The Therapy Referral Program is a program (See attachment #2), that any licensed staff member may communicate potential resident needs with the therapy department at any time and between audits for any therapy related issue, including wheel chair heights. D. Success Evaluation • Audits will be conducted by the Administrator/Designee for all new admissions weekly, until 100% compliance is achieved for one quarter and then random audits of 5 residents per month will be completed. Results of audits will be monitored and reported monthly to the QAPI committee by the Administrator/Designee. • Results of the audits will be reviewed during QAPI meetings. QAPI Committee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	085053		C 10/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MOORINGS AT LEWES	17028 CADBURY CIRCLE LEWES, DE 19958

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 54 9/28/18 - Order for "PT (Physical Therapy): evaluate and treat as indicated Continuous. 10/2/18 - Order for "OT (Occupational Therapy): Evaluate and treat as indicated: 2 times weekly for 4 weeks. 10/16/18 8:31AM - Interview with R19 stated staff was supposed to walk with the resident two times a day. Sometimes it is just once a day; someone will come at around 3:00 PM. R19 stated that staff had asked at 7:00 PM if he/she wanted to walk and R19 declined because "they have had all day long to come." R19 pointed to a brace on windowsill, which he/she stated was needed to walk. He/She explained that left knee had been replaced, but not the right knee, which sometimes "buckles". He/She again stated that he/she was supposed to walk two times a day. R19 states the walks take about 25 minutes as he/she needed to move slowly, but added that he/she wanted to stay mobile. 10/17/18 8:02 AM - Interview with R19, who stated that yesterday was the first day in two months that he/she was walked twice in one day. R19 stated that he did not like walking at 7:30 PM because he/she liked to be in bed between 6:30 PM - 7:00 PM. He/she conveyed that he/she did not go to sleep until about 9:00 PM, but preferred to be in bed earlier. 10/18/18 approximately 9:18 AM - Interview with R19, who stated that there had only been one day that he/she was ambulated twice. He/She stated that a "rehab person" came and walked with him twice during one session, but that he/she was not being walked twice a day, as "my orders specify". R19 pointed to a binder containing shower,	F 688	will identify trends and make recommendations based on audit results. F688 (2): Increase/Prevent Decrease in ROM/Mobility A. Individual/Resident Impacted • The corrective action taken for resident R19 found to have been affected by the deficient practice. Immediate action was that ambulation documentation was transferred from a notebook in the resident's room to the TAR in the EHR for CNA documentation. TAR documentation includes distance ambulated, and acceptance or refusal by the resident of the intervention. • Licensed staff were in-serviced on ADL Documentation by the RNAC. B. Identification of other residents with the potential to be affected • All residents are at risk to be potentially affected by the deficient practices. C. System Changes • The root cause(s) of the deficient practice are as identified: The staff failed to follow the care plan to ambulate the resident (R19) as planned. The resident (R19) was ambulated and also refused ambulation in several occasions but the staff failed to document as required for both completion and refusals. The therapy department did not inservice the staff regarding the ambulation plan for resident R19. • The Unit Manager/Designee will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	085053		C 10/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MOORINGS AT LEWES	17028 CADBURY CIRCLE LEWES, DE 19958

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 55 ambulation, diet sheets, which was to be signed by R19 and staff. Review of book's contents revealed that from 10/5/18 - 10/15/18, R19 was ambulated 8 times in the morning and none in the evening, noting that R19 refused once. The tracker sheet for ambulation also reflected: "goes to bed at 6:30 PM - 7:00 PM" and "prefers AM before 12:00 PM." R19 stated that E13 (CNA) would come to walk with him/her, but that E13 (CNA) does not come until later in the day, until around 2:45 - 3:00 PM. 10/18/18 - Review of Restorative Nursing Prevention and Treatment of Locomotor Dependencies for the months of September, August, July and June revealed the following: -- Statement dated 9/2018 reflected that R19 was walked 15 times out of 30 days during the 7-3 shift and 3 times out of 30 days for the 3-11 shift. -- Statement dated 8/2018 reflected that R19 was ambulated 14 times, was "N/A" (not available) 4 times and refused one time in the course of 31 days during the 7-3 shift. For the 3-11 shift in August 2018, R19 was ambulated one time and refused 3 times over 31 days. -- Statement dated July/2018 reflected that R19 was ambulated 20 times, was unavailable 1 time and refused 2 times during the 7-3 shift. For the 3-11 shift in July, R19 was ambulated 3 times and refused once. -- Statement for the time period June 12 - June 30, 2018 showed that R19 was ambulated 11 times, was not available one time and refused one time during the 7-3 shift. For the 3-11 shift in June, R19 was ambulated 5 times and refused 5 times. The notation at the bottom of each of these sheets reflect "walk with right knee brace with rollator, gait belt, close wheelchair follow assist of	F 688	document on the 24 hour report for residents that have refused to ambulate and endorse to the next shift. • The Unit Manager/Designee will audit ambulation schedule to ensure that residents on program have been offered the opportunity to ambulate. • The RNAC will in-service all staff monthly on accuracy and completion of ADL documentation, appropriate communication to the clinical staff, and use of the resident care maps. • All residents who require or request ambulation, as appropriate, will have the ambulation plan transcribed onto the TAR by the nurse inclusive of distance ambulated and acceptance or refusal by the resident. • Every month, all residents who are on an ambulation program will be discussed by the interdisciplinary team during the UR meeting to determine if the resident is still appropriate for the current plan, determine any changes in status, and refer back the therapy as needed. The summary will be documented on the existing ADL care plan by the RNAC/Designee. • The interdisciplinary team will discuss during the care plan meeting each specific resident ADL needs and refer to therapy or implement an alternative plan of care to prevent further decline, as necessary. D. Success Evaluation • The RNAC will be conducting an audit on 5 residents monthly for 6 months who are currently in an ambulation program to ensure 100% compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	085053		C 10/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MOORINGS AT LEWES	17028 CADBURY CIRCLE LEWES, DE 19958

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 56 two twice a day between 50 - 75 feet each trial. " 10/18/18 - Order: Restorative Ambulation 2 times daily with assist of 2 staff members. Assisted x2 with rolling walker on 4 of 7 days of lookback period, updated MDS. 10/19/18 7:47 AM - Interview with R19. Ambulation notebook noted not to be in the room; R19 explained that the nurse will now hold on to this book. When E13 (CNA) entered the room, R19 exclaimed, "She/He is the only aide who walks with me!" 10/19/18 2:32 PM Interview with R19; states that he/she walked with "rehab" earlier today and was hoping to walk with CNA at approximately 2:50 PM. Based on the foregoing circumstances, it was determined that the facility failed to ensure the provision of services were provided to promote mobility and ensure the highest level of practicable independence. These findings were reviewed during the exit conference on 10/24/18 beginning at 1:00 PM with E1 (NHA), E2 and E8 (Staff Educator) in person, and E4 (Clinical Analyst), E5 (Regional Nurse Consultant) and E23 (Corporate Administrator) by telephone.	F 688	• Results of the audits will be reviewed during QAPI meetings. QAPI Committee will identify trends and make recommendations based on audit results.	
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure	F 725		12/31/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	085053		C 10/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MOORINGS AT LEWES	17028 CADBURY CIRCLE LEWES, DE 19958

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 57 resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based record review, observation, interview and review of other facility documentation it was determined that the facility failed to have sufficient nursing staff to provide care and services according to acuity and individual care plans to meet the needs of the residents. three residents, five family members and six staff members (A1, A2, A3, A4, A5, A6, A7, A8, A9, F1, F2, F3, F4 and F5) out of 13 reviewed, who wished to remain anonymous, expressed concerns during the survey, in the resident council interview, and through grievance/concern forms. Findings include:	F 725	F725 Sufficient Staffing A. Individual/Resident Impacted • The corrective action taken for all residents found to have been affected by the deficient practice. Human Resources Manager is responsible for the corrective action. • The Human Resource Manager has been attending job fairs to recruit new hires, posted on job boards at Del Tech, sent flyers to the Delaware Department of Labor and placed ads in the local newspaper (The Cape Gazette.)	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	085053		C 10/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MOORINGS AT LEWES	17028 CADBURY CIRCLE LEWES, DE 19958

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 58 Cross Refer F677, F684, F686 1. 11/22/17 - A1 made a statement to hospital staff "They make me lay in my wet diaper for over an hour." 2. 1/29/18 - A12 reported that every day for the past 2 months the facility has been short staffed. 3. 1/31/18 - A13 reported that the facility was inadequately staffed over the last 2 months. 4. 2/8/18 - A2 reported "CNA taking too long to come into the room after the call bell is pushed." 5. 2/17/18 - F4 reported that only 2 CNA's were working and the resident did not get the required care. F4 stated that resident did not get checked every 2 hours for repositioning or incontinence care. 6. 2/20/18 - F4 concerned about long call bell response time on weekends. Review of call log showed the call light rang nearly 23 minutes on 2/10/18 at 6:20 PM and over 72 minutes on 2/18/18 at 9:33 AM for F4's family member. 7. 8/22/18 - Concern form by F5 about the extensive wait for call bell response. 8. 9/13/18 - A9 complained about call light response and call light log revealed over a 20 minute wait on 9/10/18 at 6:36 PM. 9. September, 2018 Resident Council meeting minutes included "Sometimes CNA's are in other rooms assisting other residents. We are currently advertising for CNA's to add additional staff". E29 (Activities Director) and E30 (Activity	F 725	B. Identification of other residents with the potential to be affected • All residents are at risk to be potentially affected by the deficient practices. C. System Changes • The Human Resource Manager/Designee will have ongoing interaction with the Corporate Recruiter to boost ads on job board sites to maximize the exposure. • The Human Resources Manager/Designee will work iHeart media to place ads regularly with a local radio station to target potential new hires. • Human Resources Manager will attend the job fair at the Rehoboth convention center as well as job fairs that are sponsored by the department of labor and the one stop shop at the Georgetown Department of Labor. • Human Resources Manager will also reach out to military spouses at Dover Air Force base. D. Success Evaluation • Scheduler/Designee will audit staffing schedules daily to ensure adequate staff are scheduled to ensure resident care is being carried out as specified in each resident care plan. • Human Resources Manager/Designee will meet with Directors to access staffing needs weekly. • The Human Resource Manager will report the results of the recruiting efforts which will include new hires and retention rates at 6 month and 12 month	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	085053		C 10/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MOORINGS AT LEWES	17028 CADBURY CIRCLE LEWES, DE 19958

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 59 Assistant) acknowledged the facility was trying to get more people and that staff were trying their best to meet needs of residents. 10. 10/15/18 (around 1:00 PM) - A7 stated that staff were working too many hours, a lot of doubles. 11. 10/15/18 - F1 expressed concern about call light wait times can exceed 20 minutes and the "lack of urgency" to answer the call lights and staff either in another room or helping with lunch. 12. 10/16/18 (8:26 AM) - A8 complained of call light response times and feeling rushed by staff. There's often understaffing with CNA's and that A8 has sat on the toilet for 25-30 minutes after ringing call bell before someone came to assist. 13. 10/17/18 (5:35 PM) - While surveyor was interviewing three CNAs in the hallway E24 (RN) yelled from next to the nursing station at the 3 CNAs in hallway for them to come up there since "several call lights" were ringing. It was not clear why the nurse did not answer any of the call lights. 14. 10/16/18 (9:35 AM) - Interview with F3 who expressed concern about being "understaffed" and losing some of "the good ones." F3 commented about the lack of available staff in the assisted dining room as resident needs increased and that food is often late or cold. F3 added about finding his/her relative "laying in urine." It used to be a five star and I thought because they get top dollar, the care would be high, but they don't have the staff. I feel the good folks don't get the recognition they deserve, even if it is just a paper certificate."	F 725	benchmarks (fifty percent) at the monthly management meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	085053		C 10/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MOORINGS AT LEWES	17028 CADBURY CIRCLE LEWES, DE 19958

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 60 15. 10/17/18 around 10:15 AM - A8 stated, "I'm at the end and don't nobody even answer." A8 continued to say that the call bell was not always placed within reach. A8 added the residents would like to be treated with dignity and respect and not have to sit on the toilet for 20-30 minutes after ringing the call bell. 16. 10/18/18 (approximately 2:10 PM) - Interview with A5 confirmed that the facility is "short staffed right now". 17. 10/19/18 (9:55 AM) - A1 stated not been fully staffed since August. When asked if nurses assist with answering call lights, A1 said that very few did and added, they [nurses] would be "outside a room when the call light comes on and let it go." 18. 10/19/18 around 10:00 AM - Interview with E38 (Scheduler) to discuss how are call outs handled. E38 makes calls to try to get coverage for the openings. When asked if temporary or contract staff are used E38 said once CNA worked a 4 hour shift and came in 2 hours early for orientation but added the agencies "don't have anyone to send us." E38 commented they have a few CNA applicants to interview and that some aides have been "let go." E38 added the unit is supposed to have 5 aides on in the day time, but many time just have four working. 19. 10/19/18 around 3:10 PM - Interview with A2, When asked "Do you have enough time to complete your required assignment each day?" A2 answered, "No" and explained that charting and ambulation would not get done. A2 added the facility did "not (sc) enough bodies to cover"	F 725		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	085053		C 10/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MOORINGS AT LEWES	17028 CADBURY CIRCLE LEWES, DE 19958

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 61 the shifts and explained there were only a few full time CNAs left. 20. 10/19/18 around 3:15 PM - Interview with A3, When asked "How often are you asked to stay late, come in early, or work overtime?" both stated "every day." When asked "Are you able to complete ROM, ambulation or other rehabilitation services as ordered for the residents?" the response was "Not all the time." 21. 10/22/18 - Interview with E2 (DON), discovered over the past two months the facility has lost a few CNAs. The census had been about the same over the past few months. Meals and breaks were covered by having assigned times so a large number of staff can't leave the floor at the same time. When asked about the expectation of answering call lights, E2 stated they should be answered "as quickly as possible." When asked who answers the call lights, E2 said "Anybody" can answer call lights. 22. 10/23/18 - A6 commented about being pulled from his/her regular job to work on the floor. The facility failed to meet professional standards in the area of sufficient nursing staff to provide the care and services to ensure the well-being and safety of residents. These findings were reviewed during the exit conference on 10/24/18 beginning at 1:00 PM with E1 (NHA), E2 (DON) and E8 (Staff Educator) in person, and E4 (Clinical Analyst), E5 (Regional Nurse Consultant) and E23 (Corporate Administrator) by telephone.	F 725		
F 730	Nurse Aide Peform Review-12 hr/yr In-Service	F 730		12/31/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	085053		C 10/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MOORINGS AT LEWES	17028 CADBURY CIRCLE LEWES, DE 19958

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 730 SS=E	Continued From page 62 CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on interview and review of other facility documentation it was determined that the facility failed to ensure a performance reviews were completed at least once every twelve months for five (E16, E17, E58, E59 and E60) out of 6 randomly sampled CNAs. The facility also failed to provide inservice education in areas needing improvement for three (E15, E16 and E58) out of 3 CNAs with a performance review containing areas for improvement. Findings include: 1. Review of the latest copy of CNA performance reviews revealed : - E15: hired 6/20/13 - review done 6/20/18, on time. - E16: hired 3/1/12 - review done 6/1/17, 3 months late. - E17: hired 3/10/17 - no review - E58: hired 5/4/09 - review done 9/11/13, over 5 years late. - E59: hired 7/19/17 - no review - E60: hired 7/12/16 - review done 12/19/17, 5 months late. During an interview conducted with E20 (HR Manager) via email on 10/19/18 at 12:18 PM, E20 (HR Manager) confirmed the missing performance reviews.	F 730	F730: Performance Review-12 hours per year In-Service A. Individual/Resident Impacted The corrective action taken for all residents found to have been affected by the deficient practice. Human Resources Manager is responsible for the corrective action. B. Identification of other residents with the potential to be affected All residents are at risk to be potentially affected by the deficient practices. C. System Changes Measures taken to ensure the problem does not recur are that Directors will be sent notification of annual reviews due on a quarterly basis. Systems that have been altered are the spreadsheet used to track reviews due and reviews completed. Any unsatisfactory scores on the annual review have a corresponding training attached and a due date for the training. Any training needed in order to correct the unsatisfactory scores on the annual review to be conducted by the Staff Educator or designee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	085053		C 10/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MOORINGS AT LEWES	17028 CADBURY CIRCLE LEWES, DE 19958

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 730	Continued From page 63 2. Three performance reviews (E15, E16 and E58) included areas for improvement involving ambulation, answering call lights promptly, reporting to nurse at start/end of shift and when leaving on break, communication skills, implementing assigned aspects of care per care plan. During an interview with E8 (Staff Educator) on 10/18/18 around 2:40 PM to determine what type of education or training had been provided based on outcomes of these reviews, E8 stated s/he was never asked to conduct training. These findings were reviewed during the exit conference on 10/24/18 beginning at 1:00 PM with E1 (NHA), E2 (DON) and E8 (Staff Educator) in person, and E4 (Clinical Analyst), E5 (Regional Nurse Consultant) and E23 (Corporate Administrator) by telephone.	F 730	Root cause of deficit practice was due to Directors not prioritizing annual reviews. In addition, previous Director of Nursing Services did not perform annual reviews for Per Diem staff. That is no longer the practice. D. Success Evaluation Human Resources Manager/Designee will contact Directors to monthly to notify them of any reviews for that month that need to be completed.	
F 732 SS=D	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides.	F 732		12/26/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	085053		C 10/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MOORINGS AT LEWES	17028 CADBURY CIRCLE LEWES, DE 19958

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 732	Continued From page 64 (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility failed to make staffing informaiton readily available in a readable format to residents and visitors. Findings include: 10/15/18 - 10/24/18 - Staffing on paper posted above the dry erase board across from the nursing station, over 5 feet off the ground with small print. The staffing information was not accessible to residents or visitors in wheelchairs or those with visual impairments. 10/24/18 (around 12:55 PM) - Interview with E2 (DON) and E8 (Staff Education) confirmed the staffing posting print was small and was not	F 732	F732 Posted Nurse Staffing Information A. Individual/Resident Impacted • There were no individuals cited; the area identified is the paper staffing copy posted about the dry erase board across from the nursing station, over 5 feet off the ground with small print. • The staffing sheet format was updated on October 26, 2018 with a larger font and on legal sized paper. A plastic frame was purchased and mounted below the white board at wheelchair level so as to be readable by residents and visitors in wheelchairs. The staffing sheet is updated daily.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	085053		C 10/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MOORINGS AT LEWES	17028 CADBURY CIRCLE LEWES, DE 19958

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 732	Continued From page 65 readable from wheelchair height. This finding was reviewed during the exit conference on 10/24/18 beginning at 1:00 PM with E1 (NHA), E2 (DON) and E8 (Staff Educator) in person, and E4 (Clinical Analyst), E5 (Regional Nurse Consultant) and E23 (Corporate Administrator) by telephone.	F 732	B. Identification of other residents with the potential to be affected • All residents are at risk to be potentially affected by the deficient practices. C. System Changes • The staffing sheet format will be displayed with a larger font and on legal sized paper. In a plastic frame mounted below the white board at wheelchair level so as to be readable by residents and visitors in wheelchairs. The staffing sheet is updated daily. • The Scheduler/Designee will ensure the posting of staffing schedules daily in the appropriate size and location. D. Success Evaluation • The location of this document will be displayed as indicated above and will not be moved. • The Administrator/Designee will verify that the staffing schedule is posted daily, ongoing at 100% compliance.	
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §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;	F 758		12/31/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	085053		C 10/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MOORINGS AT LEWES	17028 CADBURY CIRCLE LEWES, DE 19958

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 66 (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and 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.	F 758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	085053		C 10/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MOORINGS AT LEWES	17028 CADBURY CIRCLE LEWES, DE 19958

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 67 This REQUIREMENT is not met as evidenced by: Based on record review, interview and review of facility policy and procedures, it was determined that the facility failed to ensure adequate indication (specific resident behaviors) for the use of two psychotropic medications and failed to re-evaluate the need for a PRN medication for anxiety for one (R36) out of 5 sampled residents for medication review. Findings include: Facility policy entitled Administering Medications (revised 2/6/18) included: - Residents do not receive PRN psychotropic medications unless necessary to treat a diagnosed specific condition which must be documented in the record. - PRN orders for psychotropic medications which are not antipsychotic medications are limited to 14 days. The attending physician / prescriber may extend the order beyond 14 days if s/he believes it is appropriate. If the attending physician extends the PRN use for the psychotropic medication, the medical record must contain a documented rationale and determined duration. Review of R36's clinical record revealed: 9/19/18 - Admission to the facility after a fall in assisted living. 9/19/18 - Physicians' orders included psychotropic medications: - antipsychotic medication to be given twice a day for psychotic disorder with delusions. - PRN antianxiety medication for psychotic disorder with delusions.	F 758	F758 Free from Unnec Psychotropic Meds/PRN A. Individual/Resident Impacted • The corrective action taken for resident (R36) found to have been affected by the deficient practice. • The PRN order for anti-psychotic medication was discontinued on 10/15/2018 • The care plan was updated on 10/17/2018 to reflect the appropriate target behaviors for the psychotropic medications prescribed. • The PRN order for anti-anxiety medication was discontinued on 10/25/2018. • The DON requested the resident (R36) be seen by the Psychologist which occurred on 10/29/2018. • The RNAC conducted a review of all psychotropic medication orders (including PRN medications) on 10/17/2018 to ensure proper diagnosis, target behaviors and stop dates as necessary. B. Identification of other residents with the potential to be affected • All residents on psychotropic medications are at risk to be potentially affected by the deficient practices. C. System Changes • Root cause was completed to determine the cause of the deficient practice. The root cause(s)s are as identified: A lack of knowledge/training has been	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	085053		C 10/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MOORINGS AT LEWES	17028 CADBURY CIRCLE LEWES, DE 19958

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 68 9/19/18 - Admission MDS Assessment documented R36 had moderate cognitive impairment and no behaviors. There was no evidence in the clinical record describing how R36 manifested psychotic disorder with delusions for which the antipsychotic and antianxiety medications were ordered. There was lack of adequate indication for the psychotropic medications. September, 2018 - October, 2018 - Review of behavior monitoring documentation on the eMAR found behaviors were documented at the time of medication administration but there were no targeted behaviors identified. September, 2018 and October, 2018 - Review of PRN eMARs discovered the PRN antianxiety medication was not used. September, 2018 - October, 2018 - Review of physician progress notes found nothing addressing or mentioning the continued need for the antianxiety medication: September 26, October 8 and 15. 10/17/18 around 4:30 PM - Interview with E5 (Regional Nurse Consultant) revealed charting was by exception and the nurse would only document if behaviors occur. 10/17/18 at 516 PM - Interview with E4 (Clinical Analyst) who reviewed the care plan and confirmed targeted behaviors for the psychotropic medications were not included in the care plan. The 14 day re-evaluation of the PRN antianxiety medication was due 10/3/18.	F 758	identified in regards to the rules for PRN psychoactive medications and the need for identification of target behaviors for each psychotropic medication. • Nursing Supervisor/Designee will generate a listing of all psychotropic medication orders every week. • Psychotropic medication orders will be identified during 24-hour chart checks and will be reviewed to ensure appropriate diagnoses and a 14-day stop date for all psychoactive prn medication orders. • A weekly review of all residents on psychotropic medications to ensure that every order contains the appropriate diagnoses and target behaviors. • Inservice training will be provided to all clinical staff in reference to the current regulations for PRN psychotropic medications and a documented specific condition (target behaviors) needs to be identified for each psychotropic medication. Target date of completion 01/31/2019. D. Success Evaluation • DON/Designee will conduct monthly chart audits for 6 months until 100% compliance has been achieved for 3 consecutive months on the residents with ordered psychoactive drugs including auditing for inclusion of target behaviors, appropriate diagnosis a 14-day stop date on prn psychoactive medications. Results of audits will be reviewed during QAPI meetings. QAPI Committee will identify trends and make recommendations based on audit results.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	085053		C 10/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MOORINGS AT LEWES	17028 CADBURY CIRCLE LEWES, DE 19958

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 69 (Undated) - Psychiatric consultation included the resident was oriented to name, had stable mood and no delusions or hallucinations and recommended continuing with the PRN antianxiety medication for 14 days. It was unclear when the assessment occurred or why the PRN order continued when no resident behaviors were documented and the PRN medication was not administered. 10/18/18 (4:00 PM) - Interview with E2 (DON) confirmed the psychiatry consultation form was undated and unsigned by the provider and was not sure when it was completed. This finding was reviewed during the exit conference on 10/24/18 beginning at 1:00 PM with E1 (NHA), E2 (DON)and E8 (Staff Educator) in person, and E4 (Clinical Analyst), E5 (Regional Nurse Consultant) and E23 (Corporate Administrator) by telephone.	F 758		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper	F 761		12/26/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	085053		C 10/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MOORINGS AT LEWES	17028 CADBURY CIRCLE LEWES, DE 19958

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 70 temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that for one out of one medication rooms, the facility failed to date and store an injectable medication appropriately. Findings include: 10/19/18 10:33 AM - Observation in the medication room found an opened bottle of injectable medication that was untimed and undated. This finding was immediately confirmed by E26 (LPN). This medication expired 28 days from opening and without the open date written on the label, the expiration date was not known. These findings were reviewed during the exit conference on 10/24/18 beginning at 1:00 PM with E1 (NHA), E2 (DON) and E8 (Staff Educator) in person, and E4 (Clinical Analyst), E5 (Regional Nurse Consultant) and E23 (Corporate Administrator) by telephone.	F 761	F761 Label/Store Drugs and Biologicals A. Individual/Resident Impacted • No resident was negatively impacted by this deficient practice. • The medication was destroyed; a replacement was ordered and was dated when opened. B. Identification of other residents with the potential to be affected • All residents have the potential to be affected by this deficient practice. • All medications that require to be dated when opened are at risk to be potentially affected by the deficient practices. C. System Changes • A facility-wide sweep of all medication storage areas was conducted to ensure no expired medications were onsite. • A weekly inspection of medication carts will be conducted by nursing to verify all medication is in compliance (see attached weekly cart audit)	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	085053		C 10/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MOORINGS AT LEWES	17028 CADBURY CIRCLE LEWES, DE 19958

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 71	F 761	• The in-service Coordinator will conduct an in-service training to discuss the process to conduct a weekly audit of the medication carts and proper use of the audit tool. • The medication carts are sanitized monthly and during this process the Nurse will complete a Medication Cart audit to review all medications that require dating to ensure dating correctly has been accomplished. • The Pharmacy Consultant will conduct an inspection of all medication carts monthly and will provide the Healthcare Consultant Pharmacist Report monthly to the DON/Designee. D. Success Evaluation • Unit Manager/Designee to inspect and audit medication carts and storage areas weekly for 4 weeks until 4 consecutive audits are 100% compliant. And then once per month ongoing for the next 12 months. • Results of audits will be reviewed during QAPI meetings. The QAPI Committee will identify trends and make recommendations based on audit results. • The Pharmacy Consultant will report medication cart audit results to the QAPI Committee quarterly. Results of audits will be reviewed during QAPI meetings. The QAPI Committee will identify trends and make recommendations based on audit results.	
F 804 SS=D	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2)	F 804		12/31/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	085053		C 10/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MOORINGS AT LEWES	17028 CADBURY CIRCLE LEWES, DE 19958

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 804	Continued From page 72 §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility failed to serve food that was appetizing to taste and at a temperature that was palatable on 2 out of 2 test tray results. Findings include: 1. 10/15/18 at 12:13 PM - During an initial pool family interview, E20's POA stated the resident thinks the food is horrendous. There's no taste and a lot of starchy food served together like peas and mashed potatoes. One time E20 wrote a message on a napkin to the kitchen that said, "This is the worse meal ever." 2. 10/16/18 approximately 7:45 AM - During an initial pool interview, R19 stated, "I'm at the end of the hall, so I'm last to be served ... Breakfast will arrive sometimes at 8:50 AM and it is cold. You don't always get what you order'. 3. 10/16/18 at 9:35 AM - During a family interview, F3 (family member of a former resident) stated that the food served in the assisted dining room was often cold and late. 4. 10/17/18 at 8:30 AM - Test tray of a pureed breakfast was conducted in the assisted dining	F 804	F804 (1&3) Nutritive Value/Appear, Palatable/Prefer Temp A. Individual/Resident Impacted • The corrective action taken for the resident E20s POA, R19, F3 found to have been affected by the deficient practice. • The facility was unable to immediately correct the deficient practice because we were not notified of the resident's complaints or concerns at the time it occurred. B. Identification of other residents with the potential to be affected • All residents are at risk to be potentially affected by the deficient practices. C. System Changes • Every resident upon admission will be informed and encouraged to self-select items from a balanced menu for each meal. • Employees will be in-serviced by the Dietitian/designee by 12/19/18 on the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	085053		C 10/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MOORINGS AT LEWES	17028 CADBURY CIRCLE LEWES, DE 19958

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 804	Continued From page 73 room. The food temperatures were as follows: - pureed French toast: 110.9 degrees Fahrenheit (F). - pureed sausage links: 113.3 F. - pureed yogurt: 51 F. Each item was tasted and the French toast and sausage were determined to be unpalatable because they were not hot enough. 5. 10/17/18 at 12:30 PM - Test tray of a regular lunch was conducted when the last resident on the south hallway was served. The food temperatures were as follows: - broccoli soup: 135.7 degrees Fahrenheit (F). - sweet potato fries: 87.3 F. - applesauce: 49.0 F. - pudding with whipped cream: 49.0 F. - corned beef sandwich: 51.1 F. - 2% milk: 59.6 F. - iced tea: 45.0 F. The sweet potato fries were unpalatable, in terms of both limp appearance and cold temperature. These findings were reviewed during the exit conference on 10/24/18 beginning at 1:00 PM with E1 (NHA), E2 (DON) and E8 (Staff Educator) in person, and E4 (Clinical Analyst), E5 (Regional Nurse Consultant) and E23 (Corporate Administrator) by telephone.	F 804	meal pattern to assist residents in choosing a balanced meal. • Residents will be encouraged to submit Comment Cards to be turned into the Director of Dining Services to ensure communication of concerns or compliments that are food service related. • Certified Nursing Assistants will round in the dining room to ensure residents are satisfied with their meal by asking if it is to their satisfaction and documenting comments on Dining Comment Cards. • Routine monitoring of the food temperature log through the food temperature recordings completed by the assigned food service manager will ensure compliance with the regulation and ensure food remains palatable on terms of both appearance and temperature. • Additionally, the skilled nursing dining room audit will be completed by a food service manager on a routine basis to monitor that the residents are offered an alternative meal item of equal nutritive value if their intake is less than 50% of the meal initially served. • To ensure consistent and proper food temperatures, dining staff will be in-serviced by 12/19/18 by the FSD, the dietitian, or designee on proper holding temperatures and that the manager needs to be notified if improper temperatures occur so that corrections can be immediately put into place. • The Director of Dining Services/Designee will attend Resident Council as permitted by the members to discuss issues surrounding food service concerns. Any identified concerns will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	085053		C 10/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MOORINGS AT LEWES	17028 CADBURY CIRCLE LEWES, DE 19958

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 804	Continued From page 74	F 804	addressed in writing for review at the next Resident Council. D. Success Evaluation • An audit will be completed monthly for comment cards submitted and reviewed in the monthly QAPI meeting. • Any unacceptable food reviews will be addressed by the Director of Dining Services/designee to the monthly QAPI committee. F804 (2, 4&5) Nutritive Value/Appear, Palatable/Prefer Temp A. Individual/Resident Impacted • The corrective action taken for the resident E20s POA, R19, F3 found to have been affected by the deficient practice. • The facility was unable to immediately correct the deficient practice because we were not notified of the resident's complaints or concerns at the time it occurred. B. Identification of other residents with the potential to be affected • All residents are at risk to be potentially affected by the deficient practices. C. System Change • Every resident upon admission will be informed and encouraged to self-select items from a balanced menu for each meal. • Employees will be in-serviced by the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	085053		C 10/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MOORINGS AT LEWES	17028 CADBURY CIRCLE LEWES, DE 19958

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 804	Continued From page 75	F 804	Dietitian/designee by 12/17/18 on the meal pattern to assist applicable residents in choosing a balanced meal. • Residents will be encouraged to submit Comment Cards to be turned into the Director of Dining Services to ensure communication of inadequate food. • Routine monitoring of temperatures through the test tray audits completed by the assigned food service manager will ensure compliance with the regulation and ensure food remains palatable on terms of both appearance and temperature. • To ensure consistent and proper food temperatures, dining staff will be in-serviced by 01/17/19 by the FSD or the dietitian on proper holding temperatures and that the manager needs to be notified if improper temperatures occur so that corrections can be immediately put into place. • Comment cards will be placed in each room so that residents who choose to eat meals in their rooms can communicate compliments/concerns to the dietary department. • Any unacceptable food reviews will be addressed by the Director of Dining Services/designee to the monthly QAPI committee. D. Success Evaluation • An audit will be completed monthly for comment cards submitted and reviewed in the monthly QAPI meeting. • Any unacceptable food reviews will be addressed by the Director of Dining Services/designee at the monthly QAPI.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	085053		C 10/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MOORINGS AT LEWES	17028 CADBURY CIRCLE LEWES, DE 19958

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 76	F 812		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of other facility documentation, it was determined that the facility failed to ensure that food was stored properly and served under sanitary conditions. Findings include: The Centers for Disease Control and Prevention (CDC) article titled "Clean Hands Count for Healthcare Providers states, "...Hand hygiene means cleaning your hands by using either handwashing (washing hands with soap and water)...or antiseptic hand rub (i.e. alcohol-based hand sanitizer including foam or gel)...Clean your hands:...Before and after having direct contact with a patient's intact skin...After contact with	F 812	F812 Food Procurement, Store-Prepare-Serve-Sanitary A. Individual/Resident Impacted • E39 sliced a tomato on a cutting board in a food prep area and then took the cutting board to the dirty sink, placing the bottom edge of the cutting board touching the bottom of the dirty sink. After rinsing the cutting board with water E39 took the contaminated cutting board to the food prep area and made sandwiches on it. • E39 was preparing sandwiches and on 4 occasions placed the box of plastic	12/31/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	085053		C 10/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MOORINGS AT LEWES	17028 CADBURY CIRCLE LEWES, DE 19958

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 77 blood, body fluids or excretions...After contact with inanimate objects (including medical equipment)...After glove removal...Techniques for Washing Hands with Soap and Water:..When cleaning your hands with soap and water, wet your hands first with water, apply the amount of product recommended...rub your hands together vigorously for at least 15 seconds, covering all surfaces...Other entities have recommended that cleaning your hands with soap and water should take around 20 seconds. Either time is acceptable...". (https://www.cdc.gov/hand hygiene/providers/index.html) 10/11/18 - Random lunch observation in the Seahorse West kitchen and dining room during lunch from 11:30 AM through 12:30 PM: 1. E39 sliced a tomato on a cutting board in the food prep area then took the cutting board to the dirty sink, placing the bottom edge of the cutting board touching the bottom of the dirty sink. After rinsing the cutting board with water E39 took the contaminated cutting board back to the food prep area and made sandwiches on it. 2. E39 was preparing sandwiches, and on four occasions, placed the box of plastic wrap on top of clean plates and then plated sandwiches on the contaminated plates. 3. E39 did not change gloves and perform hand hygiene after contaminating gloves by touching the plastic wrap box. 4. E39 contaminated gloves by touching the top of the warmer door then touched rolls to remove them from warmer.	F 812	wrap on top of clean plates and then plated sandwiches on the contaminated plates. • E39 did not change gloves and perform hand hygiene after contaminating gloves by touching the plastic wrap box • E39 contaminated gloves by touching the top of the warmer door and then touching rolls to remove them from warmer. • E24 (RN) and E43 (Pest control) observed walking through the kitchen with no hair net in place • Staff failed to perform adequate hand hygiene related to the required minimal 15 second length of time for hand washing • E40 and E41's hair net did not cover the whole hair, just the bun • E42 (SLP) observed walking through the kitchen with no hair net in place • During the initial tour of the SNF kitchen a small refrigerator used for storing personal food of the residents had a temperature of 43.7 F. The temperature was repeated thirty minutes later and was observed to be 43.7F; food refrigerators should not be kept above 41 F. (Since this finding, this refrigerator has been removed from the unit.) • A white waxy residue was observed covering the green storage shelves in both walk in coolers and the walk in freezer in the main kitchen. When rubbed with a paper towel the white substance was removed from the shelves. (At the time of this finding, the waxy residue was cleaned up immediately and this is now on the weekly kitchen cleaning list.) • Three green buckets containing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	085053		C 10/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MOORINGS AT LEWES	17028 CADBURY CIRCLE LEWES, DE 19958

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 78 5. E24 (RN) and E43 (Pest Control) observed walking through the kitchen with no hair net in place. 10/15/18 - During a random breakfast observation in the Seahorse West dining room from 8:15 AM through 8:45 AM: 6. Staff failed to perform adequate hand hygiene related to the required minimal 15 second length of time for hand washing: - E39 (Dietary Aide) - 13 seconds. - E40 (Dietary Aide) - 11 seconds. - E41 (Dietary Aide) - first observation 11 seconds, second observation 4 seconds. 7. E40 and E 41's hair net did not cover the whole hair, just their bun. 8. E42 (Speech Therapist) observed walking through the kitchen with no hair net in place. 10/17/18 (2:20 PM) - Interview with E32 (Director of Dining Services) to review the above findings. 9. 10/15/18 at 7:22 AM - During the initial tour of the Skilled Nursing Floor kitchen a small refrigerator used for storing personal food of the residents had a temperature of 43.7 F. The temperature was repeated thirty minutes later and was observed to be 43.7 F. Food refrigerators should not be kept above 41 F. 10. 10/15/18 at 9:50 AM - A white waxy residue was observed covering the green storage shelves in both walk-in coolers and the walk-in freezer in the main kitchen. When rubbed with a paper towel; the white substance was removed from the shelves.	F 812	detergent type cleaner and wiping clothes were in use to wipe down food prep surfaces and other food contact surfaces in the main kitchen; the wiping cloths were not being held in between uses in a sanitizing solution. • A large plastic food storage container holding a cucumber, tomato, onion, ready to eat salad was observed with an improperly fitting lid, which exposed the contents to possible contamination from dust and other particles in the walk in cooler • The hand washing sink in the SNF kitchen was observed to have no signage to notify employees of expected hand washing procedures. (This was addressed immediately upon it being brought to attention.) • SNF kitchen, E54 (dining aide) and E55 (dining aide) who were in direct contact with ready to serve food were using hair restraints improperly, which did not prevent exposed food and equipment from coming in contact with their hair. • Concerns listed above were not immediately communicated by the surveyor to the Director of Dining Services at the time of the survey, as a result no immediate actions were implemented. B. Identification of other residents with the potential to be affected • All residents are at risk to be potentially affected by the deficient practices. C. System Changes	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	085053		C 10/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MOORINGS AT LEWES	17028 CADBURY CIRCLE LEWES, DE 19958

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 79 11. 10/15/18 at 1:37 PM - Three green buckets containing detergent type cleaner and wiping clothes were in use to wipe down food prep surfaces and other food contact surfaces in the main kitchen. The wiping cloths were not being held in between uses in a sanitizing solution. 12. 10/15/18 at 2:47 PM - A large plastic food storage container holding a cucumber, tomato, onion, ready-to-eat salad was observed with an improperly fitting lid, which exposed the contents to possible contamination from dust and other particles in the walk in cooler. 13. 10/16/18 at 10:23 AM - The handwashing sink in the Skilled Nursing Floor kitchen was observed to have no signage to notify employees of expected hand washing procedures. 14. 10/16/18 at 10:27 AM - Skilled Nursing Floor kitchen, E54 (Dining Aide) and E55 (Dining Aide), who were in direct contact with ready-to-serve food, were using hair restraints improperly, which did not prevent exposed food and equipment from coming in contact with their hair. 10/16/18 at 2:10 PM - Findings were confirmed by E32 (Director of Dining Services) and E33 (Dining Services Chef).	F 812	• Issues 1-5 and 7, 8, 11, 13, and 14 will be addressed through in-servicing on cross contamination provided by the FSD or the dietitian by 01/17/19. • Issue 6 will be addressed through an in-service by the FSD by 01/17/19. • Issues 10 and 12 will be addressed by adding this item to the weekly kitchen cleaning schedule. • A revised cross contamination audit will be developed to include the findings of this survey. • Issue 6: a hand washing audit will be completed weekly 5 times by a dining manager to ensure adequate hand washing and prevention of contamination of food. • Issue 10 and 12: weekly kitchen cleaning schedule audit is completed by the kitchen manager. D. Success Evaluation • The cross contamination audit will be conducted twice a week by the assigned skilled care manager; weekly audits will be reviewed by the FSD and monthly summary will be reviewed by the FSD/dietitian to make sure the plan of correction is continually implemented and monitored. • The hand washing audits will be reviewed monthly by the FSD and monthly summary will be reviewed by the FSD/dietitian to make sure the plan of correction is continually implemented and monitored. • The weekly kitchen cleaning schedule audits will be submitted to the FSD to make sure the plan of correction is	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	085053		C 10/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MOORINGS AT LEWES	17028 CADBURY CIRCLE LEWES, DE 19958

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 80	F 812	continually implemented and monitored. • Audit summaries will be reviewed at monthly dining staff meetings. • Audit summaries will be reviewed at the monthly QAPI Committee.	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;	F 842		12/21/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	085053		C 10/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MOORINGS AT LEWES	17028 CADBURY CIRCLE LEWES, DE 19958

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 81 (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review, interview and review of other facility documentation it was determined that the facility failed to ensure medical records were accurate for three (R16, R18 and R36) out	F 842	F842 Resident Records-Identifiable Information A. Individual/Resident Impacted • The resident affected (R36, R18 and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	085053		C 10/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MOORINGS AT LEWES	17028 CADBURY CIRCLE LEWES, DE 19958

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 82 of 35 sampled residents. Findings include: 1. Review of R36's clinical record revealed: 9/19/18 - Admission to the facility. a. Handwritten admission history and physical - undated, incomplete and without the R36's name. 10/17/18 (around 2:00 PM) - Interview with E25 (Social Worker) revealed the physician dictated the history and physical and sends a typed copy for the chart. b. Handwritten psychiatry consultation - Undated and unsigned. 10/18/18 (4:00 PM) - Interview with E2 (DON) confirmed the psychiatry consultation note was undated and unsigned. 2. Review of R18's clinical record revealed: 8/27/18 - Admission to facility. Handwritten admission history and physical - undated and incomplete. 10/17/18 (around 5:30 PM) - Interview with E25 (Social Worker) revealed that the physician dictated and would send the typed copy of the history and physical for the chart. E25 confirmed the form in the record was not dated. 10/18/18 (around 3:40 PM) - Interview with E10 (Physician) stated the history and physical was faxed to the facility the day prior. The document was still not on the chart at the time of the interview.	F 842	R16) History and Physical was completed and on the record with substantial compliance. B. Identification of other residents with the potential to be affected • All residents have the potential to be affected by the same deficient practice C. System Changes • Root cause of deficiency was due to a lack of auditing and monitoring process. The Medical Records staff will audit every chart weekly to ensure the History and Physicals are completed and filed in the chart. Both the Physician and Medical Records staff were involved in the establishment of this procedure. D. Success Evaluation • The Medical Records staff will perform weekly audits on all active charts for completion of History and Physicals for 6 months or until 100% compliance is achieved. (See Attachment 33) • The Medical Records staff will perform monthly audits on all active charts for completion of psychiatry notes for 6 months or until 100% compliance is achieved with continuing audits if needed. (See Attachment 34)	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	085053		C 10/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MOORINGS AT LEWES	17028 CADBURY CIRCLE LEWES, DE 19958

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 83 3. Review of R16's clinical record revealed: 5/14/18 - R16 was admitted to the facility for rehabilitation. 10/22/18 9:25 AM - During a record review, a two-page form completed in handwriting by a psychologist documented an assessment and plan did not contain a date. 10/22/18 3:45 PM - Interview with E2 (DON) confirmed that this document did not contain a date and that the facility was unable to determine when this visit occurred. These findings were reviewed during the exit conference on 10/24/18 beginning at 1:00 PM with E1 (NHA), E2 (DON) and E8 (Staff Educator) in person, and E4 (Clinical Analyst), E5 (Regional Nurse Consultant) and E23 (Corporate Administrator) by telephone.	F 842		
F 943 SS=E	Abuse, Neglect, and Exploitation Training CFR(s): 483.95(c)(1)-(3) §483.95(c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- §483.95(c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. §483.95(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property	F 943		12/31/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	085053		C 10/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MOORINGS AT LEWES	17028 CADBURY CIRCLE LEWES, DE 19958

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 943	Continued From page 84 §483.95(c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on interview and review of other facility documentation it was determined that the facility failed to ensure employees received annual training on abuse, neglect, exploitation, misappropriation of resident property and dementia management. Findings include: Review of facility training records for abuse training revealed staff members without evidence of training within the past year including new hire orientation: - Dining Services: 7 out of 47 employees (E45 - E51) all hired within past year except E49 and E50. - Housekeeping: 1 out of 7 employees (E51). - Human Resources: 1 out of 1 employee (E20). - Nursing: 3 out of 55 employees (E36, E52, E53). These findings were reviewed during the exit conference on 10/24/18 beginning at 1:00 PM with E1 (NHA), E2 (DON) and E8 (Staff Educator) in person, and E4 (Clinical Analyst), E5 (Regional Nurse Consultant) and E23 (Corporate Administrator) by telephone.	F 943	F943: Abuse Neglect and Exploitation Training A. Individual/Resident Impacted The corrective action taken for all residents found to have been affected by the deficient practice. Human Resources Manager is responsible for the corrective action. B. Identification of other residents with the potential to be affected All residents are at risk to be potentially affected by the deficient practices. C. System Changes The measures the Moorings at Lewes will take to ensure that the problem does not recur are that all new hires will be set up in Relias to be educated on Abuse and Neglect before starting work in the facility. This measure will be added to the offer letters. D. Success Evaluation Human Resources Manager/Designee will check Relias weekly to ensure compliance for new hires.	

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: The Moorings at Lewes

DATE SURVEY COMPLETED: October 24, 2018

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	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 October 15, 2018 through October 24, 2018. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records, review of facility policies and procedures and review of other facility documentation as indicated. The facility census the first day of the survey was 38 (thirty eight).	This plan of correction has been prepared to the provisions of both Federal and State laws. Preparation and/or execution of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies.	
3201.0	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	Cross reference ePOC dated 10/24/2018	11/22/2018

Provider's Signature [signature] Title Executive Director Date 11/22/18

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: The Moorings at Lewes

DATE SURVEY COMPLETED: October 24, 2018

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	COMPLETION DATE
	evidenced by: Cross Refer to the CMS 2567-L survey completed October 24, 2018: F583, F584, F609, F610, F641, F656, F677, F678, F684, F686, F688, F725, F730, F732, F758, F761, F804, F812, F842 and F943.		

Provider's Signature Title Date