DELAWARE HEALTH AND SOCIAL SERVICES
Division of Health Care Quality
Office of Long-Term Care Residents Protection

DHSS - DHCQ
263 Chapman Road
Suite 200
Newark, Delaware 19702
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: Harbor Healthcare & Rehabilitation Center **DATE SURVEY COMPLETED: February 1, 2023**

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced Annual and Complaint Survey was conducted at this facility from January 24, 2023, through February 1, 2023. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documents as indicated. The facility census the first day of the survey was one-hundred and nineteen (119). The survey sample totaled twenty-nine (29) residents.		
3201	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.0	**Scope**		
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** This requirement is not met as evidenced by: Cross refer to CMS 2567- L survey completed February 1, 2023: F550, F559, F656, F657, F658, F679, F686, F695, F697, F806 and F842.		

Provider's Signature _____ Title VHA Date 2/15/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085034	A. BUILDING _____ B. WING _____	C 02/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR HEALTHCARE & REHAB CTR	301 OCEAN VIEW BLVD LEWES, DE 19958

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E 000	Initial Comments An unannounced annual and complaint survey was conducted at this facility from January 24, 2023 through February 1, 2023. The facility census was 119 on the first day of the survey. In accordance with 42 CFR 483.73, an Emergency Preparedness survey was also conducted by The Division of Health Care Quality, the Office of Long-Term Care Residents Protection at this facility during the same time period. Based on observations, interviews, and document review, no Emergency Preparedness deficiencies were found.	E 000		
F 000	INITIAL COMMENTS An unannounced Annual and Complaint Survey was conducted at this facility from January 24, 2023 through February 1, 2023. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documents as indicated. The facility census the first day of the survey was One-hundred and nineteen (119). The survey sample totaled twenty-nine (29) residents. Abbreviations/definitions used in this report are as follows: ADON - Assistant Director of Nursing; BIMS (Brief Interview for Mental Status) - test to measure thinking ability with score ranges from 0 to 15. 13-15: Cognitively intact 8-12: Moderately impaired 0- 7: Severe impairment; CNA - Certified Nurse Aide;	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 02/17/2023

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

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F 000	Continued From page 1 DON - Director of Nursing; LPN - Licensed Practical Nurse; MD - Medical Doctor; MDS (Minimum Data Set) - a standardized set of assessments completed in nursing homes; NHA - Nursing Home Administrator; O2 - oxygen; OT - Occupational Therapy; PA - Physician Assistant RN - Registered Nurse; RNAC - Registered Nurse Assessment Coordinator; SPO2 < (less than) 90% - blood oxygen saturation level is below the desired range of 94%-100%; UM - Unit Manager. Eschar - dead tissue that is tan, brown or black and tissue damage more severe than slough in the wound bed OR dead tissue forming a hard scab; usually black in color; Granulation Tissue - mass of new connective tissue and capillaries formed on the surface of a healing ulcer or wound OR Granulation - A kind of tissue formed during wound healing, with a rough or irregular surface; Lesion - An injury or wound; Nasal cannula- tube placed into nostrils to deliver oxygen; Orthotic padding - supportive device with cushioning Oxygen saturation - measures how much oxygen is traveling through the body in the red blood cells; Pain Scale (0-10) - the most common scale for pain. Pain is identified between zero (0) to 10, with 10 being the worst pain imaginable and 0 being no pain;	F 000		

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F 000	Continued From page 2 Pulse Oximetry - measures blood oxygen saturation levels - desired range 94% to 100%; Pressure Ulcer (PU) - sore area of skin that develops when the blood supply to it is cut off due to pressure; According to the National Pressure Ulcer Advisory Panel (NPUAP 4/2016), the stages of pressure injuries/ulcers (categorization system used to describe the severity of PU's); Stage II (2) - skin blisters or skin forms an open sore. The area around the sore may be red and irritated Slough - yellow, tan, gray, green or brown dead tissue;	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all	F 550		3/20/23

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F 550	Continued From page 3 residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations and interview, it was determined that for two (R6 and R41) out of four sampled residents reviewed for dignity, the facility failed to promote care in a manner and environment that maintained or enhanced their dignity and respect. Findings include: 1. Review of R6's clinical record revealed: 2/4/21 - R6 was admitted to the facility with dementia. 1/24/23 1:18 PM - R6 was observed from the opened bedroom door in bed with the covers pulled back exposing the incontinence brief and upper right thigh. The resident's roommate was also in view of the resident. At 1:25 PM, E6 (finance staff) entered the room and referred to R6 as "this man".	F 550	A. E6 and E8 were re-educated on Resident Rights. B. All residents have the potential to be affected. C.1. The RCA was determined to be that E6 and E8 needed additional training regarding Resident Rights. 2. The Staff Developer/designee will re-educate employees on Resident Rights which will include education on avoiding labels and general phrases when referring to residents such as feeder, this man, and the need to respect the resident□s privacy by closing doors, and curtains. 3. The facility will now include this education into new hire and annual mandatory. D. 1. The NHA/designee will conduct weekly audits during of 10% of the census	

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F 550	Continued From page 4 1/26/23 12:43 PM - During a dining observation in the Henlopen dining room, E8 (CNA) referred to R6 as a "feeder". 2. 1/26/23 12:44 PM - During a dining observation in the Henlopen dining room, E8 (CNA) referred to R41 as a "feeder". 2/1/23 10:00 AM - Findings were discussed with E1 (NHA). 2/1/23 - Findings were reviewed with E1, E2 (DON) and E4 (Corporate) during the Exit Conference beginning at 1:45 PM.	F 550	mealtimes and during patient care to monitor that Resident Rights are being honored by avoiding the use of labels and general phrases when referring to residents along with respecting resident□s privacy by closing doors and curtains. 2. The audits will continue until 100% compliance is achieved for 3 months. Results of audits will be reviewed in monthly QAPI.	
F 559 SS=D	Choose/Be Notified of Room/Roommate Change CFR(s): 483.10(e)(4)-(6) §483.10(e)(4) The right to share a room with his or her spouse when married residents live in the same facility and both spouses consent to the arrangement. §483.10(e)(5) The right to share a room with his or her roommate of choice when practicable, when both residents live in the same facility and both residents consent to the arrangement. §483.10(e)(6) The right to receive written notice, including the reason for the change, before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that for one (R37) out of one resident reviewed for room and roommate change notification, it was determined that the	F 559	A. R37 was offered to change rooms and he declined. B. All residents that have a change in room or roommate have the potential to	3/20/23

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F 559	Continued From page 5 facility failed to ensure that R37 was notified of getting a new roommate on 11/1/22. Findings include: A facility policy titled, "Be Notified of Room/Roommate Change", dated 4/1/20, documented, "...to allow the resident and or their legal representative the right to choose a roommate, be notified of room changes as well as roommate changes in such a manner to acknowledge and respect resident rights." Review of R37's clinical record revealed the following: 5/17/17 - R37 was admitted to the facility. 11/1/22 - A nursing progress note documented that R37 was verbally made aware about getting a new roommate. 1/24/23 1:20 PM - During an observation in the room shared by R6 and R37, R6 was observed with periods of yelling. R37 peeked through the privacy curtain between their beds and was heard saying, "Hey buddy, can you please shut up because I am talking to this lady!" 1/24/23 1:25 PM - During an interview, R37 revealed that, "...They just brought him in that day of the move, and they did not even give me prior notice." 1/25/23 10:04 PM - A social service note documented, "...resident (R37) spoke...in depth regarding roommate...resident stated this was not fair as he was never told someone would be coming into the room in the first place...writer acknowledged that resident should have been	F 559	be affected. C. 1. The RCA was determined to be when the facility switched to a new EMR (Electronic Medical Record) the electronic Roommate Room Notification form was not carried over to the new EMR. 2. The electronic Roommate Room Notification form will be designed into the new EMR. C. The Staff Developer/designee will educate Social Services and licensed nurses on the new written (electronic) notification form in the EMR. D. 1. Social Services/designee will audit daily a 100% of residents that had a roommate or room change in the past 24 hours. The audit will monitor for compliance regarding the use of the written (electronic) notification form and provided a copy. 2. The audits will continue until 100% compliance is achieved for 3 months. Results of audits will be reviewed in monthly QAPI.	

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F 559	Continued From page 6 told about the new roommate." 1/30/23 2:30 PM - During an interview, E11 (SSD) confirmed that the facility did not notify R37 in advance of getting a new roommate. E11 further confirmed that the facility should have notified R37 in advance prior to moving R6 as his roommate on 11/1/22. 2/1/22 10:00 AM - Findings were discussed with E1 (NHA). 2/1/23 - Findings were reviewed with E1, E2 (DON) and E4 (Corporate) during the Exit Conference beginning at 1:45 PM.	F 559		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain 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).	F 656		3/20/23

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F 656	Continued From page 7 (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R97) out of twenty nine residents sampled for care plan review, the facility failed to develop and implement a comprehensive person centered care plan. Findings include: Review of the facility's Policy and Procedure titled: pain management program effective date 4/1/20 stated, "...The goal of the interdisciplinary team is to promptly identify pain and develop an effective individualized Pain Management Plan ...When a resident arrives at a center, a licensed	F 656	A. R97 pain care plan was updated to include non-pharmacological interventions. B. 1. All residents that trigger on the MDS for a Care Area Assessment for a pain care plan has the potential to be affected. 2.. All residents that triggered on the MDS for pain within the past 90 days will have their Pain Care Plan□s audited for the inclusion of non-pharmacological interventions. Corrections will be made accordingly.	

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F 656	Continued From page 8 nurse completes a comprehensive assessment of the resident using the nursing assessment form. When the nurse determines the need to look further into the resident's condition related to pain a comprehensive Pain Evaluation enables the licensed nurse to gather information regarding location, onset, and duration...". Cross refer F697. Review of R97's clinical record revealed: 3/10/22 - R97 was admitted to the facility with a diagnosis of Spinal Stenosis (a condition that painfully compresses the nerves to the lower back and legs). 3/10/22 - A pain interview (a comprehensive pain assessment) was completed and revealed that resident had pain in the last 5 days, occurring frequently, and was affecting her sleep and day to day activities. Pain interview lacked the location, type of pain (acute or chronic), and the nonpharmacological and pharmacological interventions. 3/10/22 The following baseline care plans were developed and initiated: - A baseline care plan initiated for chronic pain related to Spinal Stenosis (lower back pain) with a goal of 0 out of 10 pain. The interventions included "evaluate for presence/ absence of chest pain." - A baseline care plan initiated of potential for pain related to impaired mobility, with a goal of pain controlled to an acceptable level of 0 out of 10. The interventions included: assess for and	F 656	C. 1. The RCA was determined to be that licensed staff did not follow the Pain Management Policy. 2. The Staff Developer/designee will re-educate licensed nurses on the facility□s Pain Management policy, along with the need include non-pharmacological interventions. C. D. 1. The MDS nurse/designee will audit weekly 100% of residents that trigger on the MDS for pain to monitor for the inclusion of non-pharmacological interventions on the resident□s care plan. 2. The audits will continue until 100% compliance is achieved for 3 months. Results of audits will be reviewed in monthly QAPI.	

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F 656	Continued From page 9 address pain prior to, during and after treatments; administer pain medications as ordered; report and document complaints of pain and/or nonverbal signs of pain; reposition as needed for comfort. The facility failed to develop an individualized care plan for chronic lower back pain to include non-pharmacological interventions. 3/15/22 - An admission MDS assessment documented that R97 was alert and oriented. Additionally, the MDS documented R97 had pain, frequently, limiting day to day activities, 8 out of 10. The MDS triggered the CAA (Care Area Assessment) for pain and triggered to initiate care plan. 2/1/23 - Beginning at 1:45 PM - Findings were reviewed with E1(NHA), E2 and E4 (Corporate) during the Exit Conference.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of	F 657		3/20/23

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F 657	Continued From page 10 the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R35) out of one sampled residents reviewed for comprehensive care plans, the facility failed to review, revise and individualize R35's care plan. For R35 the facility failed to review and revise her care plan to include that excessively noisy music causes overstimulation, agitation and hollering. Findings include: Cross refer F679 and F686. 1. Review of R35's clinical record revealed: 7/22/11 - R35 was admitted to the facility with quadriplegia and was dependent on facility staff for individualized activities. 3/2/22 - R35's care plan included: "Provide one on one social visits...Staff will support (R35's) environment by providing preferred in room activities of interest i.e. personal enrichment items AEB (as evidenced by) a past enjoyment with listening to music and enjoys movies as	F 657	A. R35□s activity care plan was revised to include that noisy music can cause overstimulation, agitation, and hollering. Additionally, R35□s activities care plan interventions were updated to include, only play soft music, or relaxation tapes. B. 1. Any resident who is dependent on the facility□s staff for individualized activities have the potential to be affected. 2. Residents that are dependent on the facility□s staff for individualized activities will have their care plans reviewed to determine if potential triggers for overstimulation are included. Corrections will be made accordingly. C. 1. The RCA was determined to be that the activities care plan for R35 did not include her potential trigger (noisy music) for overstimulation. 2. The Staff Developer/designee will educate the activities staff on the need to identify potential triggers that may cause overstimulation for residents who are dependent on staff for individualized	

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F 657	Continued From page 11 tolerated." 1/27/23 1:34 PM - During an interview, E17 (Activities Aide) reported that R35 does not get out of bed and when she is in her room music makes R35 holler out. 2/1/23 8:18 AM - During an interview, E16 (Activities Director) confirmed that R35 is easily overstimulated and that loud music makes her scream and holler out. E16 confirmed that R35's care plan was not individualized to play only soft music and relaxation tapes that she tolerates much better. 2/1/23 - Findings were reviewed with E1, E2 (DON) and E4 (Corporate) during the Exit Conference beginning at 1:45 PM.	F 657	activities. D. 1. The Activities Director/ designee will audit 100% of new comprehensive or revised care plans for residents that are dependent on the facility□s staff for activities. The audit will monitor for the inclusion of potential triggers for overstimulation on the care plan. 2. The audits will continue until 100% compliance is achieved for 3 months. Results of audits will be reviewed in monthly QAPI.	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that for one (R3) out of three residents reviewed for pressure ulcer (PU), the facility failed to ensure services provided by the facility met the professional standards of quality as it relates to assessment of stage 2 PU. Findings include: 1/27/23 9:23 AM - An observation of R3's wound during wound care revealed a shallow, pea-sized	F 658	1. E7 was educated on the NPUAP (National Pressure Ulcer Advisor Panel) staging system. 2. A. All residents with a pressure ulcer have the potential to be affected. B. A whole house audit of residents with pressure ulcers will be conducted to review accuracy of reporting the staging of the wound as per the NPUAP staging system.	3/20/23

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F 658	Continued From page 12 open area located on the left (L) lower buttocks with scant serous (a thin, clear, light yellow watery fluid found in many body cavities) drainage and no granulation tissue present. 1/27/23 9:40 AM - During an interview, E7 (LPN) explained that R3's wound was a Stage 2 Pressure Ulcer (PU). 1/27/23 2:28 PM - A progress note documented R3's wound as, "L [Left] buttocks noted with area being treated for MASD [Moisture-associated skin damage] with zinc, [was] reclassified to a stage II [2] today... 100% granulation...." 2/1/23 10:02 AM - During an interview, E7 (LPN), the assessment of R3's wound compared to the NPUAP (National Pressure Ulcer Advisory Panel) staging system was reviewed. The NPUAP definition of a Stage 2 Pressure Injury states, "...Granulation tissue, slough and eschar are not present...." E7 (LPN) confirmed a stage 2 PU does not have granulation tissue and R3's wound was a stage 2 PU. E7 incorrectly identified the tissue type in R3's wound. 2/1/23 1:45 PM - Findings were reviewed with E1 (NHA), E2 (DON) and E4 (Corporate Nurse) during the exit conference.	F 658	Corrections will be made accordingly. 3. A. The RCA was determined to be that E7 was not familiar with the NPUAP staging system. B. The Staff Developer/designee will educate licensed nursing on the NPUAP staging system. C. The DON/designee will audit all pressure ulcers weekly for accuracy of staging using the NPUAP staging system. 4. The results of the audits will be presented in the facility□s monthly QAPI meeting until 100% compliance is achieved for 3 months.	
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing	F 679		3/20/23

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F 679	Continued From page 13 program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, it was determined that for one (R35) out of one sampled residents reviewed for activities, the facility lacked evidence that R35 was provided an ongoing consistent program of activities to include one on one room visits per R35's plan of care. Findings include: Cross refer F657. 1. Review of R35's clinical record revealed: 7/22/11 - R35 was admitted to the facility with quadriplegia and was dependent on facility staff for individualized activities. 3/2/22 - R35's care plan included: Provide one on one social visits... During random observations on 1/24/23 at 1:47 PM, 1/25/23 at 11:35 AM, 1/26/23 at 9:21 AM and 11:58 AM, and 1/27/23 at 9:03 AM and 12:46 PM R35 was in bed with the television on and either sleeping or staring aimlessly. Review of R35's activity record revealed that the facility lacked evidence of one on one visits for all of October 2022. November of 2022 R35 was only provided one on one visits on 11/26 through 11/30. December of 2022 R35 was only provided	F 679	A. R35□s activity care plan was revised to include that noisy music can cause overstimulation, agitation, and hollering. Additionally, R35□s activities care plan interventions were updated to include, only play soft music, or relaxation tapes. B. 1. Any resident who is dependent on the facility□s staff for individualized activities have the potential to be affected. 2. Residents that are dependent on the facility□s staff for individualized activities will have their care plans reviewed to determine if potential triggers for overstimulation are included. Corrections will be made accordingly. C. 1. The RCA was determined to be that the activities care plan for R35 did not include her potential trigger (noisy music) for overstimulation. 2. The Staff Developer/designee will educate the activities staff on the need to identify potential triggers that may cause overstimulation for residents who are dependent on staff for individualized activities. D. 1. The Activities Director/ designee will audit 100% of new comprehensive or revised care plans for residents that are dependent on the facility□s staff for activities. The audit will monitor for the	

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F 679	Continued From page 14 one on one visits from 12/1 through 12/8, 12/15 and 12/22. January 2023 R35 was only provided a one on one visit on 1/31. 01/27/23 01:35 PM - During an interview, E17 (Activities Aide) confirmed that R35 had not been out of bed or provided one on one activities all week. E17 stated that there was not always activity staff to accommodate one on one room visits to residents related to staffing shortages. 2/1/23 - During an interview, E16 (Activities Director) confirmed that the facility lacked evidence of an ongoing activities program that included one on one visits except for the aforementioned dates. 2/1/23 - Findings were reviewed with E1, E2 (DON) and E4 (Corporate) during the Exit Conference beginning at 1:45 PM.	F 679	inclusion of potential triggers for overstimulation on the care plan. 2. The audits will continue until 100% compliance is achieved for 3 months. Results of audits will be reviewed in monthly QAPI.	
F 686 SS=D	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	F 686		3/20/23

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F 686	Continued From page 15 by: Based on observation, record review and interview, it was determined that for two residents' (R29) and (R79) out of three sampled residents reviewed for pressure ulcers, the facility failed to provide care and services to prevent avoidable pressure ulcers. Findings include: 1. Review of R29's clinical record revealed: 6/12/12 - R29 was admitted to the facility after a stroke. A facility policy and procedure undated titled: Treatment/Services to Prevent/Heal Pressure Ulcers included: 1.The facility will ensure that based on the comprehensive assessment of a resident: a. A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's condition demonstrates that they were unavoidable. 12/19/22 - Braden scale (tool used to determine risk for development of pressure ulcers). Braden score for R29: 18 minimal risk for pressure ulcer development. 12/27/22 - R29's Quarterly MDS documented... R29 was an extensive assist of two staff for turn and reposition. A care plan last revised 1/9/23 included to check the resident's skin every two hours, report abnormalities to the nurse and turn and reposition every two hours and as needed.	F 686	A. 1. R29 is now being turned side to side every two hours. 2. R79□s order for left hand padding has been clarified. 2. R79 is now wearing her right-hand palm protector as per the physician□s order. B. 1. All residents who are extensive assist (two person) have the potential to be affected.2 2. All residents who have an order for a palm protector and/or orthotic padding, have the potential to be affected. 3. A whole house audit of all residents that have orders for palm protectors and/or orthotic padding will be conducted. The audit will review compliance to the physician order. Corrections will be made accordingly. C. 1. The RCA for R29 was determined to be that staff were not following the facility□s protocol for turning and repositioning. 2. The RCA for R79 was determined to be that staff were not following the physician□s order for the palm protector and orthotic padding. 3. The Staff Educator/designee will re-educate licensed nurses and C.N.A. on the need to turn and reposition every two hours and as ordered. 4. The Staff Educator/designee will re-educate licensed nurses on the need to follow physician orders regarding palm protectors, and orthotic padding. D. 1. The DON/designee will audit 2 residents per week who require extensive assist (2 person) and will	

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F 686	Continued From page 16 1/6/23 - A physicians order included: Apply zinc barrier cream to right buttock MASD (moisture associated skin damage) every shift leave open to air, observe peri-wound (surrounding tissue) and wound observation for deterioration. 1/6 and 1/14/23 - A wound consult note indicates the presence of a lesion (injury or wound) at the sacrum (large triangular bone at base of spine), moisture associated skin damage, erythema (a diffuse redness over the skin) , excoriation (break in the skin surface) and the patient is at risk for developing a pressure injury. Continue off-loading and turn per facility policy. 1/24/23 10:00 AM - R29 was observed in bed laying on his back. 1/24/23 12:56 PM - R29 was observed in the bed the head and foot of the bed are raised heels are not offloaded. 1/25/23 10:27 AM - R29 was observed in bed laying on his back. 1/25/23 11:12 AM - During an interview, R29 he reported that he gets out of bed once a week, because he has something on is butt and he needs a patch on it. 1/25/23 3:19 PM - R29 was observed in bed and laying on his back with the head of the bed slightly raised his upper body was leaning to the left side of the bed. R29's lunch tray is sitting on his bedside table and positioned in front of him. 1/26/23 06:41 AM - A progress note composed by E22 (LPN) documented ..." applied zinc to sacrum for reddened skin as a barrier ..." No skin	F 686	monitor compliance to the turning schedule. 2. The DON/designee will audit 2 residents per week who have orders for palm protectors and/or orthotic padding. The audit will monitor compliance to the physician orders regarding palm protectors and padding. 3. The audits will continue until 100% compliance is achieved for 3 months. Results of audits will be reviewed in monthly QAPI.	

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F 686	Continued From page 17 issues noted." 1/26/23 9:19 AM - R29 was observed in bed and laying on his back, the head and foot of his bed were both raised. 1/26/23 10:20 AM - During observation of personal care, R29 was noted to have an open area to his sacrum. 1/26/25 10:20 AM - During an interview, E19 (PA) stated "yes, it is a stage 2 pressure ulcer." 1/26/23 11:28 AM - A progress note composed by E5 (RN, UM) included: "he developed a stage 2 pressure ulcer." 1/30/23 9:45 AM - R29 was observed in bed laying on his back, the head of the bed was up, and his breakfast tray was on his bedside table in front of him. 1/30/23 - 11:52 AM - R29 was observed in the bed laying on his back the head of the was raised. R29 was leaning to the left side of the bed. 1/31/23 9:02 AM - R29 was observed in bed laying on his back, the head of the bed was raised. 1/31/23 1:12 PM - During an interview, R29 stated ... "no they are not turning me at all, they can turn me either way if it's going to help me get better, I don't mind." 1/31/23 1:12 PM - During an interview, E21 (CNA) stated " he doesn't refuse care with turning and repositioning."	F 686		

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F 686	Continued From page 18 The facility failed to show that R29, an extensive two staff person assist with a history of pressure ulcers, was turned side to side in order to prevent skin breakdown. 2/1/23 - Findings were reviewed with E1 (NHA), E2 (DON) and E4 (Corporate) during the Exit Conference beginning at 1:45 PM. 2. Review of R79's clinical record revealed: 5/14/19 - R79 was admitted to the facility with dementia. 9/28/22 - Staff training for contracture management included: for the left and right hands ...R79 to wear right hand palm protector during 7-3 shift with transition to orthotic padding and left hand to use orthotic padding between all digits; palm changed one time a day for skin integrity and hygiene. 11/21/22 - Braden score for R79: 13 moderate risk for pressure ulcer development. 11/30/22 - R79's Quarterly MDS documented ...is total assist for ADL's (activities of daily living). A care plan last revised 12/13/22 included: Resident is to have hand protectors removed daily to have skin inspected, resident to wear right palm protector and left-hand orthotic padding from 7:00 AM to 3:00 PM daily. 12/21/22 - A physicians order included: Patient to wear left orthotic padding daily in between digits and palm as tolerated for skin integrity and contracture management; to be changed one	F 686		

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F 686	Continued From page 19 time a day for hygiene. 12/21/22 - A physicians order included: Patient to wear customized palm protector during 7-3 shift as tolerated with removal for skin checks and hygiene. 1/25/23 9:05 AM - R79 observed not wearing orthotic padding to the left hand and was not wearing a right palm protector to the right hand. White gauze was in the palm of the right and left hands. 1/25/23 9:22 AM - Review of documentation by E5 ...Palm protector sent to laundry ...Second palm protector not located. 1/30/23 8:54 AM - During an interview E20 (OT) stated that "R79 had a skin integrity issue with the bilateral contractures her nails were digging into her skin, the orthotic padding for the left hand was ordered but had been difficult to place in between her fingers and her skin was very moist in between her fingers so the white gauze was used to try to help with the moisture ...E20 stated ... "the gauze was different from the actual order." ... E20 stated "yes the white gauze is acceptable." During an observation E20 separated the left thumb away from R79's forefinger and a pressure area was observed on the inside of R79's left thumb. E20 stated ... "nursing was educated on how to place the gauze in between R79's fingers." E20 stated ..."it is a stage 2 pressure area." 1/30/23 9:07 AM - During an interview, E2 (DON) stated ..." she had an order for orthotic padding back in March, I don't know if it got lost or it may be in the laundry."	F 686		

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F 686	Continued From page 20 1/30/23 9:22 AM - During an observation and interview, E2 (DON), E3 (ADON), and E23 (RN) confirmed R79 did not have the orthotic padding in her left hand or gauze per the physicians' orders. In addition, E2, E3, and E23 observed the open area between R79's left thumb and forefinger. 2/1/23 8:53 AM - During an interview, E24 (RN) confirmed ..."yes we got an education from occupational therapy on how to place the gauze between her fingers and then there was a special cream that you would work in between her fingers, oh and so when you use the orthotic padding it was like a soft palm protector that was used to keep her fingernails from digging into her skin her hand and fingers are so contracted." 2/1/23 10:50 AM - During an interview, E20 ... there was skin breakdown back in March with my evaluation ... E20 stated " I observed a stage 2 pressure area to R29's left thumb, obviously if I had known of that area she would have been picked back up by therapy." 2/1/23 - Findings were reviewed with E1 (NHA), E2 (DON) and E4 (Corporate) during the Exit Conference beginning at 1:45 PM.	F 686		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered	F 695		3/20/23

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F 695	Continued From page 21 care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that for one (R21) out of one sampled resident reviewed for respiratory care, the facility failed to ensure that R21 was provided respiratory care consistent with his physician orders and comprehensive person - centered care plan. Findings include: Review of R21's clinical record revealed: 12/23/22 - R21 was readmitted from the hospital with diagnoses including dementia and pneumonia. 1/5/23 - R21 had a physician's order for "oxygen at 2 L (liters)/minute to keep sats (oxygen saturation) greater than 92% via nasal cannula every shift." 1/5/23 - R21 had a physician's order to obtain SPO2 (oxygen saturation) every shift. 1/6/23 - A care plan was developed for R21's oxygen therapy with the goal for R21 to have no signs and symptoms of poor oxygen absorption through the review date. R21's interventions included but not limited to administering O2 (oxygen) at 2L/minute with the use of the nasal cannula (tube placed into nostrils to deliver oxygen). 1/24/23 10:18 AM - An observation of R21 in his room revealed that R21 was receiving oxygen therapy via nasal cannula connected to the oxygen concentrator at 1 L/min. The oxygen	F 695	A. R21 is now receiving oxygen therapy and monitoring as per the physician□s order. B. All residents that are on oxygen therapy have the potential to be affected. C. 1. The RCA was determined to be that licensed nurses did not follow the physician□s order regarding his oxygen therapy and monitoring. 2. The Staff Developer/designee will re-educate the licensed nurses on the need to follow physician orders for oxygen therapy and monitoring. D. 1. The DON/designee will audit 2 residents weekly that have oxygen to monitor compliance to the physician□s order. 2. The audits will continue until 100% compliance is achieved for 3 months. Results of audits will be reviewed in monthly QAPI.	

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F 695	Continued From page 22 tubing was not labeled and dated. 1/26/23 10:30 PM - During an observation, R21's portable oxygen tank was hung on the back of his wheelchair with the oxygen tubing coiled and placed in a plastic bag and hung on the back of his wheelchair. R21 was not wearing his ordered oxygen. 1/26/23 12:14 PM - During another observation, R21 was seen self propelling his wheelchair to his room from the hallway. R21's portable oxygen tank was hung on the back of the wheelchair with the oxygen tubing coiled and placed in the plastic bag and hung on the back of the wheelchair. R21 did not have his oxygen in use. 1/26/23 2:51 PM - R21 was observed sitting in his wheelchair in the front lobby. R21's portable oxygen tank was hung at the back of the wheelchair with the oxygen tubing coiled and placed in the plastic bag and hung on the back of the wheelchair. R21 did not have his oxygen in use. 1/26/23 2:55 PM - During an interview, R21 told the surveyor that E7 (LPN) told him that he did not have to use the oxygen all the time anymore. R21 further stated, "The nurse (E7) told me that I will be monitored." 1/27/23 11:05 AM - Review of R21's O2 Sats Summary revealed a lack of evidence that R21's SPO2 level was monitored on 1/26/23. 1/27/23 3:16 PM - In a joint interview, E7 and E15 (LPN) both confirmed that R21 still had an active order for continuous oxygen.	F 695		

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F 695	Continued From page 23 2/1/23 10:00 AM - Findings were discussed with E1 (NHA). 2/1/23 - Findings were reviewed with E1, E2 (DON) and E4 (Corporate) during the Exit Conference beginning at 1:45 PM.	F 695		
F 697 SS=G	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to provide pain management according to professional standards of practice for one (R97) out of three residents sampled for pain. R97 was not provided pain medication causing unrelieved pain for approximately six hours resulting in harm. Findings include: November 2009 - The American Academy of Pain Medicine, "Pharmacological Management of Persistent Pain in Older persons, stated to refer to the previous American Geriatrics Society for specific recommendations for pain assessment in older persons that remain relevant." April 2002 - The pain management standards by the American Geriatrics Society included: appropriate assessment and management of pain; assessment in a way that facilitates regular reassessment and follow-up; same quantitative	F 697	A. 1. R97 is now receiving her routine dose of Oxycodone medication. 2. R97□s pain care plan has been updated to include specific interventions for spinal stenosis. B. 1. All residents who have an order for Oxycodone have the potential to be affected. 2. All residents with a pain care plan have the potential to be affected. 3. A whole house audit of pain care plans will be conducted. Care plans will be reviewed for the inclusion of an acceptable pain level, pharmacological interventions, non-pharmacological interventions, and specific interventions related to spinal stenosis if the resident has the diagnosis. C. 1. The RCA was determined to be that the quantity of Oxycodone in the back up box was not sufficient to cover a delay	3/20/23

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F 697	Continued From page 24 pain assessment scales should be used for initial and follow up assessment; set standards for monitoring and intervention; and collect data to monitor the effectiveness and appropriateness of pain management. Review of the facility's Policy and Procedure titled: Pain Management Program, effective date 4/1/20, stated, "... Purpose: Promote recognition and intervention to manage pain at the individual's goal or tolerance level to promote the highest quality of life practible (sic)... The goal of the interdisciplinary team is to promptly identify pain and develop an effective individualized Pain Management Plan... When a resident arrives at a center, a licensed nurse completes a comprehensive assessment of the resident using the nursing assessment form. When the nurse determines the need to look further into the resident's condition related to pain a comprehensive Pain Evaluation enables the licensed nurse to gather information regarding location, onset, and duration; Pain intensity and description... Controlled Pain Management Program is a static program that has been developed and tested to meet the resident's needs, and that manages (controls) the resident's pain when implemented properly...". Cross refer F656. Cross refer F842. Review of R97's clinical record revealed: 3/10/22 - R97 was admitted to the facility with a diagnosis of Spinal Stenosis (a condition that painfully compresses the nerves to the lower back and legs)	F 697	in the pharmacy delivery schedule over a holiday weekend. 2. The facility will review and revise the par levels of Oxycodone that is available in the back up box for emergencies. 3. The Staff Developer will re-educate licensed nurses on the facility□s Pain Management Program policy. 4. Now the facility will review quantity of emergency of back up box whenever the supply does not meet the need. 5. The Staff Developer will re-educate licensed nurses on the need to obtain an accurate hold order including the correct dosage when prescribed pain medication (s) are not available. Additionally the Staff Developer will re-educated licensed nurses on the need to consult with the on-call provider when prescribed pain medication(s) are not available and the prescribed PRN medication(s) are ineffective. D. 1. The DON/designee will audit daily 100% of residents whose prescribed pain medication(s) are not available. The DON/designee will audit the hold order, and was the on- call provider notified when prescribed pain medication(s) are not available and the prescribed PRN medication(s) are ineffective. 2. The audits will continue until 100% compliance is achieved for 3 months. Results of audits will be reviewed in monthly QAPI.	

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F 697	Continued From page 25 3/10/22 - A comprehensive pain assessment revealed the resident had pain in the last five days, occurring frequently, and it was affecting her sleep and day to day activities. The comprehensive pain assessment lacked the location, type of pain (acute or chronic), and non pharmacological and pharmacological interventions. 3/10/22 - A baseline care plan initiated for chronic pain related to Spinal Stenosis (lower back pain) had a goal of 0 out of 10 pain (using scale of 0 being no pain and 10 being the worst possible pain). Interventions included to evaluate for the presence/ absence of chest pain, but failed to include interventions specific to pain with spinal stenosis. 3/10/22 - A baseline care plan initiated for potential for pain related to impaired mobility with a goal of pain to be controlled to an acceptable level of 0 out of 10. Interventions included: assess for and address pain prior to, during and after treatments; administer pain medications as ordered; report and document complaints of pain and/or nonverbal signs of pain; reposition as needed for comfort. 3/15/22 - An admission MDS assessment documented that R97 was alert and oriented. Additionally, the MDS documented R97 had pain, frequently, limiting day to day activities, pain scale 8 (very severe) out of 10. The MDS triggered the CAA (Care Area Assessment) for pain and triggered to initiate a care plan. 4/4/22 - A Physicians order for Acetaminophen tablet 500 mg give 1 tablet by mouth every 6 hours as needed for pain/discomfort. Gabapentin	F 697		

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F 697	Continued From page 26 300 mg by mouth every 8 hours for low back pain. 4/5/22 - A review of Physician's orders revealed an order for Voltaren Gel 1% (pain relieving cream) apply to low back topically four times a day for low back pain. 4/22/22 - A Physicians order for Oxycodone (an opioid pain medication sometimes called a narcotic; used to treat moderate to severe pain) tablet 15 mg give 1 tablet by mouth every 6 hours for pain. 4/28/22 - A Physicians order revealed an acceptable pain level for R97 of 0 out of 10 every shift. 5/26/22 8:29 PM - Review of progress notes revealed a PRN (as needed) Tramadol (pain reliever) was adminsitered for a pain level 8 out of 10. 5/27/22 12:00 AM - Review of MAR (Medication Administration Record) revealed Oxycodone 15 mg was not given, a code of "7" (meaning sleeping) for reason. 5/27/22 1:12 AM - A progress note revealed PRN administration of Tramadol was effective. 5/27/22 1:50 AM - Review of the Individual Controlled Substance record for R97 revealed routine Oxycodone 15 mg was unavailable and one dose (three 5 mg tablets) was removed from the emergency box. 5/27/22 2:15 AM - A progress note documented that Oxycodone 15 mg (12 AM dose) was not	F 697		

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F 697	Continued From page 27 administered. "R97 had prn pain med earlier and is currently asleep." The MAR documented a code of "7." 5/27/22 6:00 AM - Review of the MAR revealed the 6:00 AM dose of Oxycodone 15mg was administered from the Emergency box. 5/27/22 12:15 PM - Review of the Individual Controlled Substance record for R97's routine Oxycodone 15 mg was unavailable and one dose (three 5 mg tablets) from the emergency box was removed. This left no more back up doses in the emergency box. 5/27/22 5:35 PM - Review of the MAR documented PRN Tramadol was administered with a pain score of 8 out of 10. 5/27/22 6:00 PM - Review of the MAR for Oxycodone revealed a code of "5" which signified "Hold/ See progress notes." 5/27/22 6:19 PM - A progress note documented Oxycodone not administered due to waiting for delivery from the pharmacy. 5/27/22 6:30 PM - A Physician's Order was written to hold Oxycodone 5mg (incorrect dose) one dose for chronic pain. The facility failed to ensure the resident's routine Oxycodone was acquired, thus, the resident was not administered her medication at 6:00 PM. In addition, the facility failed to obtain an accurate order from E25 (MD) to hold the Oxycodone 15 mg. 5/27/22 9:32 PM - A progress note documented a post (after) pain assessment scale of 5 out of 10 from the PRN Tramadol dose at 5:35 PM.	F 697		

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F 697	Continued From page 28 5/27/22 10:57 PM - Acetaminophen (used to treat mild pain and fever) was administered for a pain level of 10 out of 10. 5/27/22 11:12 PM - Review of the MAR documented that PRN Tramadol was given for a pain level of 10 out of 10. 5/27/22 Untimed - Review of the MAR documented that R97 verbalized a pain level of 10 out of 10 during the night shift assessment. 5/28/22 12:00 AM - Review of the MAR for Oxycodone documented a code of "9" or "Other/See Progress Notes." 5/28/22 1:12 AM - A progress note documented a post assessment pain score of 10 out of 10 after administration of Acetaminophen and Tramadol. Despite R97's pain being at 10 out of 10, the facility failed to consult the attending physician for alternative pain relief and failed to obtain Oxycodone from a pharmacy. 5/28/22 1:46 AM - A progress note documented (Oxycodone) "En route from pharmacy." 5/28/22 4:45 AM - Review of the MAR documented Oxycodone 15 mg was administered ten hours and forty five minutes after the dose oxycodone. 5/28/22 6:00 AM - Review of the MAR documented that routine Oxycodone 15 mg was administered, despite being administered one hour and fifteen minutes before. 5/28/22 Untimed - Review of the MAR shift pain	F 697		

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F 697	Continued From page 29 assessment documented that R97 verbalized a pain level of 8 out of 10. 1/30/23 10:30 AM - An interview with E5 (RN) revealed that the facility was unable to obtain Oxycodone on 5/27/22 and she was advised by the off going shift to give Oxycodone as soon as it was available. 1/30/23 11:40 AM - Review of findings with E2 (DON) confirmed that the facility ran out of the Oxycodone on 5/27/22 and should have consulted the on call provider regarding the ineffective pain medication administered in the absence of Oxycodone. At this time, E2 (DON) confirmed that the facility failed to provide medication to control R97's pain resulting in six hours of severe uncontrolled pain rated at a level of 10 out of 10. 2/1/23 - Beginning at 1:45 PM - Findings were reviewed with E1 (NHA), E2 and E4 (Corporate) during the Exit Conference.	F 697		
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by:	F 806		3/20/23

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F 806	Continued From page 30 Based on observation, interview and record review, it was determined that for one (R37) out of two residents reviewed for food preferences, the facility failed to accommodate R37's food preferences or choices. Findings include: 5/17/17 - R37 was admitted to the facility. 1/24/23 1:22 PM - During an interview, R37 revealed that he has been keeping a stack of his January 2023 meal tickets encircling the lack of condiments which were not included when his food trays were served. The surveyor reviewed the meal tickets (varying from breakfast, lunch and dinner indicating R37 was to receive salt and pepper). R37's meal tickets suggested that his meals were missing condiments including salt, pepper and margarine. 1/26/23 10:35 AM - During a follow up interview, R37 revealed that, "...The breakfast food tray did not have the usual condiments on it." 1/26/23 12:19 PM - Review of R27's lunch meal ticket revealed that R37 was to receive 1 single serve packet of salt, 2 single serve packets of sugar, 1 single serve packet of pepper and 3 single serve amounts of margarine. On that same observation, it was revealed that R37's tray was missing salt, sugar, pepper and margarine, contrary to what was indicated on his meal ticket. 1/26/23 12:21 PM - E9 (CNA) entered R37's room and handed 3 single serve amounts of margarine to R37. 1/26/23 12:21 PM - During an interview, R37 revealed that the condiments were not included in the food tray that was just served. In addition,	F 806	A. R37 is now receiving all condiments listed on his meal ticket. B. All residents that request condiments listed on their meal ticket has the potential to be affected. C. 1. The RCA was determined to be that the C.N.A. did not provide the condiments to R37 because she knew that he had a stock pile in his room. 2. The Staff Developer/designee will re-educate C.N.A.□s on the need to provide residents with the condiments listed on their meal ticket even if resident has a stockpile in their room. D. 1. The Food Service Director/designee will conduct weekly audits of 10% of the census to monitor that condiments are on the meal trays. Audits will be conducted during various mealtimes. 2. The audits will continue until 100% compliance is achieved for 3 months. Results of audits will be reviewed in monthly QAPI.	

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F 806	Continued From page 31 R37 stated, "I had to ask the CNA to give me the margarine." 1/26/23 1:01 PM - During an interview, E9 told the surveyor that the CNAs give out the condiments as indicated in the residents' meal tickets. When asked if the CNA included the condiments on R37's lunch tray which was served to R37 earlier, E9 stated that she did not include the condiments on R37's tray. E9 further stated, "I know he has a lot of supplies of sugar, salt and pepper packets in his room, and I thought he could use them. I did not want these condiments to go to waste, so I didn't include them in R37's tray." 2/1/23 10:00 AM - Findings were discussed with E1 (NHA). 2/1/23 - Findings were reviewed with E1, E2 (DON) and E4 (Corporate) during the Exit Conference beginning at 1:45 PM.	F 806		
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	F 842		3/20/23

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F 842	Continued From page 32 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; (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-	F 842		

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F 842	Continued From page 33 (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 interview, record review and review of other facility documentation it was determined that the facility failed to ensure, in accordance with professional standards and practices, that medical records for one (R97) out of twenty-three sampled residents was accurate. Findings include: Review of facility's Policy and Procedure titled: Documentation and Inventory of Controlled Substances, with an effective date of September 2020 stated "...Policy: Controlled drugs are inventoried and documented under proper conditions with regard to security and state/federal regulations... Separate individual narcotic records are maintained on all Schedule II drugs in the form of a declining inventory... This form includes Customer Name, Prescriber name, Prescription Number, drug name, strength, dosage form, dosage, total quantity received by the facility, date and time of administration, signature of person administering the drug...". Cross Refer F697. Review of R97's clinical record revealed:	F 842	A. E5 was educated on the need to complete the Individual Controlled Record in its entirety. B. All residents that receive controlled medications have the potential to be affected. C. 1. The RCA was determined to be that E5 was unaware of the need to complete the bottom portion of the Individual Controlled Record 2. The Staff Developer will re-educate licensed nurses on the need to complete the Individual Controlled Record in its entirety. D. 1. The DON/designee will audit weekly 25% of any new Controlled Records received in the past week to monitor that the record was completed in its entirety. 2.The audits will continue until 100% compliance is achieved for 3 months. Results of audits will Be reviewed in monthly QAPI.	

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HARBOR HEALTHCARE & REHAB CTR	301 OCEAN VIEW BLVD LEWES, DE 19958

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F 842	Continued From page 34 3/10/22 - R97 was admitted to the facility. 1/26/23 11:49 AM - A review of R97's Individual Patient Controlled Record form for Oxycodone lacked evidence of staff receiving the drug including date, time, and amount received. 1/30/23 10:30 AM - An interview with E5 (RN) confirmed that she was working on the night of 5/27/22 and the Oxycodone was delivered from the pharmacy on 5/28/22. E5 confirmed she received the Oxycodone. 1/30/23 10:40 AM - An interview with E2 (DON) confirmed that the facility lacked evidence of completing the Individual Patient Controlled Record for R97's Oxycodone. 2/1/23 - Beginning at 1:45 PM - Findings were reviewed with E1, E2 (DON) and E4 (Corporate) during the Exit Conference.	F 842		