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

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

STATE SURVEY REPORT

NAME OF FACILITY: Breakwater Village (Harbor Health) **DATE SURVEY COMPLETED:** March 20, 2024

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced Annual, Complaint and Emergency Preparedness survey was conducted at this facility from March 11, 2024, through March 20, 2024. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documents, as indicated. The facility census the first day of the survey was one hundred ten (110). The survey sample totaled thirty-seven (37) 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 the CMS 2567-L survey completed March 20, 2024: F584, F609 F635, F641, F644, F684, F711, F802, F805, F812, F842 and F919.		

Provider's Signature _____ Title NHA Date 4/8/24

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3201.7.0 3201.7.5	**Plant, Equipment and Physical Environment.** **Kitchen and Food Storage Areas. Facilities shall comply with the Delaware Food Code.** Based on observations, interview, and review of other facility documentation it was determined that the facility failed to comply with the Delaware Food Code. Findings include: **Delaware Food Code 2-101.11- ... the PERMIT HOLDER shall be the PERSON IN CHARGE or shall designate a PERSON IN CHARGE and shall ensure that a PERSON IN CHARGE is present at the FOOD ESTABLISHMENT during all hours of operation.** **Delaware Food Code 2-102.11 ...The PERSON IN CHARGE shall demonstrate this knowledge by : (B) Being a certified FOOD protection manager who has shown proficiency of required information through passing a test that is part of an ACCREDITED PROGRAM...** 3/11/24 10:24 AM - During interview, E27 (Dietary Aide), disclosed that only one (1) staff member in the food service department possessed a valid Food Protection Manager certificate from an Accredited Food Safety Program.		

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	085034	A. BUILDING _____ B. WING _____	C 03/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BREAKWATER VILLAGE	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 March 11, 2024 through March 20, 2024. The facility census was 110 on the first day of the survey. In accordance with 42 CFR 483.73, an Emergency Preparedness survey was also conducted by The Division of Health Care Quality, the Office of Long-Term Care Residents Protection at this facility during the same time period. Based on observations, interviews, and document review, no Emergency Preparedness deficiencies were identified.	E 000		
F 000	INITIAL COMMENTS An unannounced Annual, Complaint and Emergency Preparedness survey was conducted at this facility from March 11, 2024 through March 20, 2024. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documents, as indicated. The facility census the first day of the survey was one hundred ten (110). The survey sample totaled thirty-seven (37) residents. Abbreviations/definitions used in this report are as follows: ADON - Assistant Director of Nursing; CNA - Certified Nurse Aide; DON - Director of Nursing; DOT - Director of Therapy; LPN - Licensed Practical Nurse; MAR - Medication Administration Record; MD - Medical Doctor; MDS - Minimum Data Set;	F 000		

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

Electronically Signed | 04/11/2024

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

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NHA - Nursing Home Administrator;
OT - Occupational Therapy;
PT - Physical Therapy;
RN - Registered Nurse;
RNAC - Registered Nurse Assessment Coordinator;
SW - Social Worker;
UM - Unit Manager.

Abilify - A medication that works in the brain to treat schizophrenia;
ADL - Activities of daily living;
Agitation - emotional state of restlessness;
Alzheimer's Disease - degenerative disorder that attacks the brain's nerve cells resulting in loss of memory, thinking and language;
Anxiety - unpleasant state of inner turmoil, often accompanied by nervous behavior, such as pacing back and forth;
Ativan - a medication is used to treat anxiety;
Bilateral - affecting both sides;
BIMS - (Brief Interview for Mental Status) - assessment of the resident's mental status. The total possible BIMS Score ranges from 0 to 15 with 15 being the best:
0-7: Severe impairment (never/rarely made decisions)
08-12: Moderately impaired (decisions poor; cues/supervision required)
13-15: Cognitively intact (decisions consistent/reasonable);
Bipolar Disorder - mood disorder;
Bisacodyl- laxative, oral and suppository form;
Blood sugar- amount of sugar or glucose in the blood;
Buspirone - a medication that treats anxiety;
Care Plan - outlines the plan of action that will be implemented during a patient's medical care;
Catheter - a small tube used for fluid to drain;

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Cervical - having to do with the neck;
Clonazepam - a medication used to treat seizures, panic disorder, and anxiety;
Cognition - mental process; thinking;
Delirium - acutely disturbed state of mind;
Dementia - a severe state of cognitive impairment characterized by memory loss, difficulty with abstract thinking, and disorientation;
Hallucinations - something that seems real but does not really exist;
Hospice care pack -medication for comfort including morphine, ativan, haldol, reglan;
Idiopathic - of unknown cause;
Mechanical soft diet- smoother texture than regular foods; eliminates foods that are difficult to chew or swallow;
Medication Administration Record (MAR) - list of daily medications to be administered;
Minimum Data Set (MDS) - standardized assessment forms used in nursing homes;
Milk of magnesia (MOM) - laxative;
Neurogenic bladder - a person lacks bladder control due to a brain, spinal cord, or nerve condition;
Parkinson's disease - a progressive disorder of the nervous system that affects your movement or a disorder of the brain that leads to shaking (tremors) and difficulty with walking. movement, and coordination;
PASSR - Preadmission Screening and Resident Review - screening for evidence of serious mental illness and/or intellectual disabilities, developmental disabilities or related conditions. to ensure that individuals are thoroughly evaluated and they are placed in nursing homes only when appropriate and that they receive all necessary services while they are there;
Psychiatry - the branch of medicine that deals with the causation, prevention, diagnosis and

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F 000	Continued From page 3 treatment of mental and behavioral disorders; Psychology - study of behavior and mind; Psychosis - loss of contact/touch with reality; Polyneuropathy - multiple nerves outside the brain and spinal cord are damaged; Psychotropic (medication) - medication capable of affecting the mind, emotions and behavior; Schizophrenia - mental disorder with false beliefs of being harmed; Seroquel - an antipsychotic medication that treats several kinds of mental health conditions including schizophrenia and bipolar disorder; Sertraline - A medication used to treat depression; Suppository - drug administered into the rectum; Therapeutic diet- A therapeutic diet is tailored to meet the nutritional needs of an individual based on their specific health condition or illness; Trazadone - a drug used to treat depression. It may also be used to help relieve anxiety and insomnia (trouble sleeping).	F 000		
F 584 SS=D	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	F 584		5/3/24

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F 584	Continued From page 4 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); §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 for one room out of five rooms reviewed for environmental concerns the facility failed to provide a clean and homelike environment. Findings include: Random observations of room 126 revealed: 3/11/24 10:37 AM - An observation of room 126 revealed the following: -A substantial amount of dirt and food crumbs scattered throughout the bedroom.	F 584	1. R126□s room was cleaned, and the baseboard was repaired. 2. " Any resident who only allows a specific employee to clean their room has the potential to be affected. " The facility reviewed all residents' cleaning schedules to determine if any other resident only allows certain employees to clean their rooms. No others were identified.	

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F 584	Continued From page 5 -The bathroom revealed a substantial amount of small, circular black debris scattered throughout the floor. Also, next to the toilet had a circular area, brown in color approximately 12 inches by 6 inches in size. -There was approximately 3 feet of baseboard peeling off the wall and onto the floor. During this observation, an interview with the resident stated that (baseboard) has been that way for a year. The resident stated he told maintenance about it. 3/12/24 10:58 AM - An observation of room 126 revealed that there continued to be dirt and food crumbs scattered throughout the bedroom floor and the bathroom continued to have the same black debris and circular area on the floor. While in room 126, an interview with the resident stated that no one ever came in the room and cleaned it yesterday (3/11/23). 3/12/24 11:10 AM - During an observation and interview, E24 (Floor Tech) confirmed that room 126 was unclean and proceeded to clean the room. After the bathroom was cleaned, the circular black debris and the circular area by the toilet were removed from the floor. E24 stated the resident's rooms are to be cleaned every day including sweeping and wet moping the floor. 3/12/24 11:13 AM - An interview with E24 confirmed the baseboard in room 126 and that it had been that way for about one year. E24 stated he notified E26 (Director of Maintenance) about a year ago. 3/14/24 1:39 PM - An interview with E26 confirmed the baseboard peeling off the wall and laying on the floor of room 126. E26 stated an employee of the facility may have verbally told	F 584	3. " The RCA determined that resident R126 only allowed one housekeeping staff member to clean his room. " R126 has now identified other staff members to clean his room so it can be cleaned routinely. " The new system entails the Housekeeping Director reporting out in morning meeting residents who are declining room cleaning during morning meetings for the IDT to help devise solutions. " The NHA/designee will audit R126's room weekly for cleanliness until 100% compliance is achieved for three consecutive months and as needed. 4. " Results of the audits will be reported in the monthly Quality Assurance and Assessment (QA&A) meetings until 100% compliance is achieved for three consecutive months and as needed.	

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F 584	Continued From page 6 him but the issue did not get put into their maintenance system to be followed. E26 stated he will get the baseboard fixed. 3/18/24 1:54 PM - An observation of room 126 revealed the baseboard was appropriately attached to the wall of the room and was no longer peeling off. 3/18/24 1:54 PM - An interview with E25 (Director of Environmental Services) revealed that resident rooms are to be cleaned every day including sweeping and wet moping the floor and cleaning the bathroom. E25 confirmed there are four housekeepers that clean the resident rooms; however, they use E24 to clean room 126 because resident prefers him. The resident stated he does prefer E24 to clean his room but is acceptable to having two of the four housekeepers clean his room. 3/20/2/24 2:40 PM - Findings reviewed with E1 (NHA), E2 (DON) and E3 (ADON) and E4 (Corporate) during the exit conference.Based on observation and interview, it was determined that for one room out of five rooms reviewed for environmental concerns the facility failed to provide a clean and homelike environment. Findings include:	F 584		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(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	F 609		5/3/24

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F 609	Continued From page 7 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 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 and interview, it was determined that for one (R255) out of three residents reviewed for abuse, the facility failed to report a bruise of unknown origin. Findings include: 9/26/23 - An admission MDS assessment documented R255 had a BIMS score of 3 (severe cognitive impairment). 10/10/23 6:20 AM - A skin and wound note documented, "resident noted with left upper arm bruise of unknown origin while care was being provided."	F 609	1. " The State Agency is now aware of R255□s bruise of unknown origin. 2. " Any resident with a bruise of unknown origin has the potential to be affected. " The facility conducted a 30-day review of incident reports to identify any residents that have a bruise of unknown origin and to ensure that incidents were reported to the State Agency. No other incidents were identified. 3. " The RCA determined that the staff failed to identify a bruise of unknown origin as a reportable event to the State	

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F 609	Continued From page 8 10/10/23 - A facility incident report documented that R255 had a bruise to the left upper arm. No measurements or description was documented in R255's clinical record. R255 was unable to explain what happened. 10/11/23 12:10 AM - An order note documented, "monitor left upper arm bruise until resolved every shift." 10/12/24 2:07 AM - An order note documented, "monitor right upper arm and chest bruise until resolved every shift for monitoring." The facility lacked evidence that a bruise of unknown origin was reported to the state agency within the required eight-hour time frame. 3/20/24 12:34 PM - During an interview, E2 (DON) confirmed that the family was not notified. Additionally, E12 confirmed that the incident was not reported to the State Agency. 3/20/2/24 2:40 PM - Findings reviewed with E1 (NHA), E2 (DON) and E3 (ADON) and E4 (Corporate) during the exit conference.	F 609	Agency. " The Staff Developer/designee re-educated licensed nurses on the need to report bruises of unknown origin to the State Agency timely. " The new system involves the DON/designee reviewing incident reports during the morning meeting to identify any unexplained bruises that have been reported to the state agency and will report accordingly. " The DON/designee will audit weekly incident reports for bruises of unknown origin and ensure timely reporting to the State Agency until 100% compliance is achieved for three consecutive months and as needed. 4. " Results of the audits will be reported in the monthly Quality Assurance and Assessment (QA&A) meetings until 100% compliance is achieved for three consecutive months and as needed.	
F 635 SS=D	Admission Physician Orders for Immediate Care CFR(s): 483.20(a) §483.20(a) Admission orders At the time each resident is admitted, the facility must have physician orders for the resident's immediate care. This REQUIREMENT is not met as evidenced by: Based on interviews and review of the clinical record, it was determined that for one (R309) out of two residents reviewed for admission, the	F 635	1. " R309 now has orders for her Foley Catheter and Diabetic Management.	5/3/24

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F 635	Continued From page 9 facility failed to ensure that R309 had physician orders for the resident's immediate care. Findings include: 1 a. Review of R309's clinical record revealed: 3/6/24 - R309 was admitted to the facility. 3/6/24 6:30 PM - An admission assessment was completed for R309 indicating an indwelling urinary catheter in place. 3/6/24 - A care plan was initiated for indwelling urinary catheter. 3/9/24 - An admission MDS indicated R309 had an indwelling urinary catheter. 3/11/24 11:02 AM - An observation of R309 revealed an indwelling catheter in place and bag in a privacy bag. An interview with R309 confirmed use of indwelling urinary catheter related to neurogenic bladder (retention of urine). 3/12/24 9:32 AM - A physician's order revealed R309 use of indwelling urinary catheter related to neurogenic bladder. 3/13/24 2:22 PM - An interview with E19 (CNA) confirmed R309 was admitted with an indwelling urinary catheter and care was being completed. 3/14/24 1:08 PM - An interview with E15 (UM) confirmed the admission process is completed by the admitting nurse. The admitting nurse is responsible for admission assessments and inputting of physician orders. 3/14/24 1:30 PM - An interview with E18 (RN)	F 635	2. " Any residents who are admitted to the facility with a Foley Catheter and the need to for Diabetic Management has the potential to be affected. " The facility conducted an audit of all residents admitted with a Foley Catheter and Diabetic Management the past 7 days for order accuracy. Orders were obtained as indicated. 3. " The RCA determined that the facility failed to perform the new admission checklist for R309. " The Staff Developer/designee reeducated licensed staff on the need to utilize the admission checklist for all new admissions. The checklist now includes foley catheter and diabetic management as the system change. " The DON/designee will audit 100% of new admission to monitor for that the new admission checklist was completed. Audits will continue until 100% compliance is achieved. 4. " Results of the audits will be reported in the monthly Quality Assurance and Assessment (QA&A) meetings until 100% compliance is achieved for three consecutive months and as needed.	

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F 635	Continued From page 10 confirmed that R309 was admitted on 3/6/24 and E18 completed the admission assessments and orders. E18 stated R309 was admitted with an indwelling urinary catheter, and she forgot to obtain the batch orders (set of orders) related to the catheter from the provider. b. Review of R309's clinical record revealed: 3/6/24 - A care plan was initiated for diabetes management for R309. 3/6/24 6:30 PM - An admission assessment was completed for R309 and did not indicate that R309 was diabetic. 3/6/24 7:00 PM - A physician's order was written for Levemir (Insulin) and glipizide (oral diabetic) medications. 3/12/24 1:05 PM - A physician's order for R309 was written for blood glucose monitoring before meals and at bedtime. Additionally, an order was written for sliding scale insulin coverage with blood glucose results. 3/14/24 1:08 PM - An interview with E15 (UM) confirmed the admission process is completed by the admitting nurse. The admitting nurse is responsible for admission assessments and inputting physician orders. 3/14/24 1:30 PM - An interview with E18 (RN) confirmed that R309 was admitted on 3/6/24 and E18 completed the admission assessments and orders. E18 stated R309 was diabetic, and she forgot to obtain the batch orders (set of orders) related to the diabetic management from the provider.	F 635		

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F 635	Continued From page 11 The facility failed to ensure physician's orders needed for immediate care were present on admission. 3/20/2/24 2:40 PM - Findings reviewed with E1 (NHA), E2 (DON) and E3 (ADON) and E4 (Corporate) during the exit conference.	F 635		
F 644 SS=E	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that for five (R41, R309, R14, R65, R5 and R90) out of eight residents reviewed for PASARR, the facility failed to ensure that a referral for a PASARR screening was completed. Findings include:	F 644	1. " R41, R309, R14, R65, R5, and R90 now have PASARR□s. 2. " All residents that require a PASARR have the potential to be affected.	5/3/24

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F 644	Continued From page 12 1. Review of R41's clinical record revealed: 12/6/23 - R41 had a PASARR I completed at the hospital with the indication of no level II needed and no suspected or confirmed PASARR conditions. 12/19/23 - R41 had a PASARR completed at a different facility with indication of level I negative and no suspected or confirmed PASARR conditions. 12/22/23 - R41 was admitted to the facility with diagnosis of persistent mood affective disorder, unspecified. 12/29/23 - R41 had an initial psychology visit for admission. 1/4/24 - R41 had the following follow up visits with psychology: 1/4/24, 1/11/24, 1/25/24, and 2/8/24. 1/27/24 - R41 had a change in condition that required R41 to be sent to the hospital. R41 was diagnosed with psychosis and the facility failed to add the new diagnosis to the medical record. 3/14/24 11:41 AM - An interview with E6 (SW) confirmed that R41 did not have a PASARR level II or a submission for review to the State PASARR authority. 3/14/24 12:36 PM - An email correspondence with S1 (State PASARR Authority) confirmed that the facility should have submitted a resident review PASARR for R41 for the diagnosis of psychosis, which is a qualifying diagnosis. The resident review PASARR may not have resulted	F 644	" The facility conducted an audit of 100% of residents that require a PASARR. " PASSARRs obtained accordingly. 3. " The RCA determined that the facility did not have a system for identifying new diagnoses and medications that require a new PASARR. Additionally, the Admission Director admitted residents without a PASARR. " The Staff Developer educated MDS coordinators and Social Workers on the new system for tracking new diagnoses and medications that now require a PASSAR. " The Staff Developer/designee will be re-educated the Admission Director on the PASSAR process. " The DON/designee will audit 100% of residents with new diagnoses and medications that require PASARR. Audits will be conducted until 100% compliance is achieve for three consecutive months. 4. " Results of the audits will be reported in the monthly Quality Assurance and Assessment (QA&A) meetings until 100% compliance is achieved for three consecutive months and as needed.	

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F 644	Continued From page 13 in a full level II but another PASARR evaluation should have occurred in this instance. 2. Review of R309's clinical record revealed: 3/4/24 - The hospital completed a PASARR I for R309 that did not indicate a level was II needed and no suspected or confirmed PASARR conditions. The PASARR I lacked R309's diagnoses of anxiety disorder, adjustment disorder with depressed mood, and insomnia. 3/6/24 - R309 was admitted to the facility with the following diagnoses: anxiety disorder, adjustment disorder with depressed mood, and insomnia. The facility failed to review the PASARR I completed from the hospital and verify accuracy related to R309's admitting diagnoses. 3/14/24 11:41 AM - An interview with E6 (SW) confirmed that R41 did not have a PASARR level II or a submission for review to the state PASARR. 3/14/24 12:36 PM - An email correspondence with S1 (State PASARR Authority) confirmed that R41 The facility should have submitted a resident review PASARR at least for the diagnoses of anxiety and adjustment disorder with depressed mood. The resident review PASARR may not have resulted in a full level II but another PASARR evaluation should have occurred in this instance. 3. Review of R14's clinical record revealed: 6/18/18 - A PASARR Level 1.5 evaluation was completed for R14 with an outcome stating no Level II evaluation required.	F 644		

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F 644	Continued From page 14	F 644		

6/19/18 - R14 was admitted to the facility.

6/22/23 - A psychiatry consult note by E 20 (Psychiatry NP) stated that R14 had an increase in behaviors.

7/11/23 - A medication order for Abilify 2 mg tablet, give 2 mg by mouth two times a day for bipolar disorder.

The aforementioned medication order was increased from once a day to twice a day.

9/7/23 - A medication order for Abilify 5 mg tablet, give 5 mg by mouth at bedtime for bipolar disorder.

The aforementioned medication order was increased from 4 mg a day to 5 mg a day.

12/14/23 - A progress note by E21 (SW) stated that the facility physician informed her that R14 mentioned " ...wanting to harm himself ... psych NP visited with resident then ...".

12/14/23 - A psychiatry consult note by E17 (Psychiatry NP) stated that R14 was overheard by a provider that he made passive suicidal ideation remarks. E17 increased R14's sertraline medication from 50 mg a day to 75 mg a day.

12/29/23 - A new medication order of buspirone 7.5 mg tablets, give 1 tablet by mouth two times a day for anxiety disorder was added to R14.

3/14/24 11:40 AM - An interview with E6 confirmed that the facility did not submit a request for a new PASARR for R14 after a change in his

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F 644	Continued From page 15 behaviors and psychoactive medications were added and altered. 4. Review of R14's clinical record revealed: 1/12/23 - A PASARR Level I evaluation was completed for R65 with an outcome stating no Level II evaluation required. 1/13/23 - R65 was admitted to the facility. 6/15/23 - A new diagnosis of unspecified psychosis not due to a substance or known physiological condition was identified. 7/11/23 - A physician progress note for R65 stated, " ... atypical psychosis due to dementia/Hallucinations continue with (Psych contractor) psychiatric nurse practitioner. Currently on ativan, trazodone and seroquel." 11/29/23 - A psychiatry consult note by E17 stated that the visit was a follow-up for R65 resisting and combative with care. 3/14/24 11:40 AM - An interview with E6 confirmed that the facility did not submit a request for a new PASARR for R65 after the new diagnosis was added. E6 stated, "He (R65) is one that should have been submitted for." 5. Review of R5's clinical record revealed: 12/29/15 - R5 was admitted to the facility. 11/14/17 - A PASARR 1.5 was completed for R5 with an outcome stating "The individual does not have a serious mental illness (SMI) but further review of level of impairment, recent treatment history, or other circumstances demonstrates that	F 644		

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F 644	Continued From page 16 a full II is not required ..." 1/18/22 - A new diagnoses of schizophrenia, anxiety disorder unspecified, and major depressive disorder, recurrent, moderate were identified. 10/24/22 - A new diagnosis of unspecified dementia, unspecified severity, with other behavioral disturbance was identified. 12/16/22 - A new diagnosis of bipolar disorder, unspecified, was identified. 1/25/23 - A new diagnosis of unspecified psychosis not due to a substance or know physiological condition was identified. 3/14/24 12:40 PM - In a telephone interview, S1 (PASARR State Authority) confirmed there should have been a resident review in 2022 as the PASARR 1.5 from 2017 is not a true reflection of R5's current clinical status. 3/15/24 11:41 AM - In an interview, E6 (SW) a second level PASARR will be requested if there was an increase in behaviors or if a resident did not previously have a psychiatric diagnosis. E6 stated that she had been told in trainings that with the addition of a psychiatric diagnosis, Maximus does not want a new submission. E6 further stated that since the PASARR 1.5, R5's behaviors have been consistent. Based on interview and record review, it was determined that for one (R5) out of seven residents reviewed for PASARR, the facility failed to ensure that a referral for a PASARR screening	F 644		

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F 644	Continued From page 17	F 644		

was completed. Findings include:

Review of R5's clinical record revealed:

12/29/15 - R5 was admitted to the facility.

11/14/17 - A PASSAR 1.5 was completed for R5 with an outcome stating "The individual does not have a serious mental illness (SMI) but further review of level of impairment, recent treatment history, or other circumstances demonstrates that a full II is not required ..."

1/18/22 - A new diagnoses of schizophrenia, anxiety disorder, unspecified, and major depressive disorder, recurrent, moderate were identified.

10/24/22 - A new diagnosis of unspecified dementia, unspecified severity, with other behavioral disturbance was identified.

12/16/22 - A new diagnosis of bipolar disorder, unspecified, was identified.

1/25/23 - A new diagnosis of unspecified psychosis not due to a substance or know physiological condition was identified.

3/14/24 12:40 PM - In a telephone interview, S1 (PASARR State Authority) confirmed there should have been a resident review in 2022 as the PASARR 1.5 from 2017 is not a true reflection of R5's current clinical status.

3/15/24 11:41 AM - In an interview, E6 (SW) a second level PASARR will be requested if there was an increase in behaviors or if a resident did not previously have a psychiatric diagnosis. E6

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F 644	Continued From page 18 stated that she had been told in trainings that with the addition of a psychiatric diagnosis, Maximus does not want a new submission. E6 further stated that since the PASSAR 1.5, R5's behaviors have been consistent. 3/20/2/24 2:40 PM - Findings reviewed with E1 (NHA), E2 (DON) and E3 (ADON) and E4 (Corporate) during the exit conference. 6. Review of R90's clinical record revealed: 6/25/23 - R90 had a PASARR Level I pre-admission screening with the indication of no level II needed and no suspected or confirmed PASARR conditions. 8/1/23 - R90 was admitted to the facility with a diagnoses of major depressive disorder,anxiety disorder unspecified, Alzheimer's disease unspecified,dementia unspecified severity, with behavioral disturbance, psychotic disorder with delusions,and unspecified psychosis. 2/1/2024 - R90 had a trauma care assessment for PTSD. 8/10/23 - R90 had a psychiatry consult and follow up visits on 8/17/23, 10/5/23, 10/13/23, 11/2/23, 11/16/23, 11/30/23, 1/4/24, 1/11/24, 1/22/24, 1/25/24, 2/1/24, and 2/15/24. 2/12/24 - A significant change MDS assessment revealed a change in mood state, staff assessment indicated the total severity score was greater than the prior assessment, and delirium.	F 644		

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F 644	Continued From page 19 Symptoms of delirium are indicated by the presence of an acute mental status change. 3/14/24 11:40 AM - An interview with E6 confirmed that the facility did not submit a request for a level II PASARR for R90 after a change in condition. 3/13/24 12:36 PM - An email correspondence with S1 (State PASARR Authority) confirmed that for R90 the facility should have submitted a review for a level II PASARR for the admission diagnoses and the change in condition. 3/20/2/24 2:40 PM - Findings reviewed with E1 (NHA), E2 (DON) and E3 (ADON) and E4 (Corporate) during the exit conference.	F 644		
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 interview and record review it was determined that for one (R313) out of one residents reviewed for bowel and bladder incontinence care, the facility failed to ensure that R313 received treatment and care in accordance with professional standards of practice and physician orders. Findings include:	F 684	1. " The facility is now following the physician orders regarding constipation for R313. 2. " All residents experiencing constipation have the potential to be affected. A review	5/3/24

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F 684	Continued From page 20 1. Review of R313's clinical record revealed: 6/19/23 - The EMR diagnosis page documented that R313 was admitted to the facility with a diagnosis of chronic idiopathic constipation. 6/19/23 Review of the physician's orders included medications for constipation: - Milk of magnesia (MOM)- give 30 ml by mouth every 24 hours as needed for constipation If no BM x 9 shifts. -Bisacodyl suppository- insert 1 suppository rectally every 24 hours as needed for constipation. Administer if MOM is ineffective or NO bowel movement x 10 shifts. -Bisacodyl oral tablets- give 10 mg by mouth every 24 hours as needed for Constipation. -Senna s tablets- give 2 tablets by mouth in the evening every other day for constipation. -Miralax powder- give 17 grams by mouth one time a day every other day for constipation Administer with 8 oz of fluids. 7/1/23 through 9/30/23 - The CNA documentation of R313's BM activity revealed that the facility failed to ensure that physician's orders were implemented when R313 failed to have bowel movements for nine (9) shifts on the following dates: -Ending on evening shift 7/14/23 - total 20 shifts -Ending on evening shift 9/2/23 - total 22 shifts -Ending on night shift 9/7/23 - total 15 shifts 7/1/23 through 9/30/23 - A review of the MAR's for R313 revealed that the facility lacked evidence of monitoring and initiating bowel protocol for any of the above dates.	F 684	of current resident charts will be conducted to determine whether a bowel protocol needs to be initiated. The protocol will be initiated as indicated 3. " The RCA determined that the facility did not follow the facility□s bowel protocol. " The Staff Developer/designee re-educated licensed nurses on the bowel protocol to include following orders and conducting a bowel assessment. " The Staff Developer/designee will re-educate C.N.A.□s on documentation of bowel movements. " The system change now involves discussing residents requiring bowel protocol initiation during the morning meeting, with a focus on including monitoring for bowel assessment. " The DON/designee will conduct weekly audits of residents who have not had bowel movements for compliance to following physician orders and conducting a bowel assessment. The audits will be conducted until 100% compliance is achieved for three months. 4. " Results of the audits will be reported in the monthly Quality Assurance and Assessment (QA&A) meetings until 100% compliance is achieved for three consecutive months and as needed.	

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F 684	Continued From page 21 7/1/23 through 9/30/23 - A review of the progress notes for R313 lacked evidence that the facility monitored or completed bowel assessments related to above dates. 3/20/24 9:19 AM - An interview with E16 (RN) confirmed the bowel protocol occurs after no bowel movement for nine shifts and the nurse would administer MOM. Nurses should be completing a bowel assessment and monitor for bowel movements. If one does not occur, then the next step of bisacodyl oral or suppository is administered. E16 confirmed that R313 did not receive the bowel protocol during the above dates. 3/20/2/24 2:40 PM - Findings reviewed with E1 (NHA), E2 (DON) and E3 (ADON) and E4 (Corporate) during the exit conference.	F 684		
F 711 SS=D	Physician Visits - Review Care/Notes/Order CFR(s): 483.30(b)(1)-(3) §483.30(b) Physician Visits The physician must- §483.30(b)(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; §483.30(b)(2) Write, sign, and date progress notes at each visit; and §483.30(b)(3) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications.	F 711		5/3/24

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F 711	Continued From page 22 This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, it was determined for one (R309) out of one resident reviewed for physician visits, the facility failed to ensure the physician reviewed the total program of care, including medications and treatments. Findings include: Review of R309 clinical record revealed: 3/6/24 - R309 was admitted to the facility. 3/6/24 6:30 PM - An admission assessment was completed for R309 indicating an indwelling urinary catheter was in place. 3/9/24 - An admission MDS indicated R309 had an indwelling urinary catheter. 3/9/24 0:00 AM - A physician's progress note revealed a history and physical completed for R309. The progress note assessed the genitourinary system and lacked evidence of an indwelling urinary catheter in place. 3/11/24 11:02 AM - An observation of R309 revealed an indwelling catheter in place and a bag in a privacy bag. An interview, R309 confirmed use of an indwelling urinary catheter related to neurogenic bladder (retention of urine). 3/12/24 9:32 AM - A physician's order revealed R309's use of an indwelling urinary catheter related to neurogenic bladder. 3/19/24 1:39 PM - An interview with E5 (NP) confirmed that the provider did not mention the use of an indwelling catheter, or an assessment	F 711	1. 1" R309 now has orders for her indwelling catheter. 2. " All residents who have an indwelling catheter have the potential to be affected. " The facility conducted an audit of 100% of residents with indwelling catheters to monitor for orders and documentation of the device on history and physical. Corrections made accordingly. 3. " The RCA found that E5 (NP) failed to identify the indwelling catheter and initiate orders. " The Staff Developer/designee will re-educate E5 NP on the need to write orders for an indwelling catheter and document the device in the history and physical. " The system change involves updating the admission checklist to now include monitoring for indwelling catheters. " The DON/designee will audit weekly 100% of residents who were admitted with an indwelling catheter and monitor for orders and documentation in the history and physical. The audit will be conducted until 100% compliance is achieved for three months. 4. " Audit results will be reported in	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BREAKWATER VILLAGE	301 OCEAN VIEW BLVD LEWES, DE 19958

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F 711	Continued From page 23 related to it's use. E5 confirmed that R309 was admitted with the catheter in place and does not recall initiating physician's orders related to the catheter. This resulted in six days without indwelling urinary catheter orders. 3/20/2/24 2:40 PM - Findings reviewed with E1 (NHA), E2 (DON) and E3 (ADON) and E4 (Corporate) during the exit conference.	F 711	monthly QA&A meetings until achieving 100% compliance for three consecutive months and as needed.	
F 802 SS=D	Sufficient Dietary Support Personnel CFR(s): 483.60(a)(3)(b) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.60(a)(3) Support staff. The facility must provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. §483.60(b) A member of the Food and Nutrition Services staff must participate on the interdisciplinary team as required in § 483.21(b)(2)(ii). This REQUIREMENT is not met as evidenced by: Based on observation, document review and interview it was determined that the facility failed to ensure that a qualified person in charge was present in the kitchen during all hours of food service operation. Findings include:	F 802	1. " Cooks are now required to take the Food Protection Program. 2. " All residents have the potential to be	5/3/24

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F 802	Continued From page 24 3/11/24 10:24 AM - During interview, E27 (Dietary Aide), disclosed that only one (1) staff member in the food service department possessed a valid Food Protection Manager certificate from an Accredited Food Safety Program. 3/20/24 2:40 PM - Findings reviewed with E1 (NHA), E2 (DON) and E3 (ADON) and E4 (Corporate) during the exit conference.	F 802	affected. " The personnel files of the cooks were audited for an active Food Protection certification. Any cook without an active Food Protection certificate will be enrolled in the program. 3. " The RCA determined that the cooks had a Serve Safe certificate instead of a Food Protection Manager certificate. " The facility has implemented a system change wherein cooks are now required to possess a Food Protection certificate. Additionally, the facility will offer the course to cooks who do not currently hold a certificate. " The Staff Developer/designee will educate the Food Service Director on the requirement for cooks to have a Food Protection certificate. " The HR/designee will audit the personnel files of newly hired cooks for a Food Protection certificate. This will be an ongoing audit. 4. " Audit results will be reported in monthly QA&A meetings until achieving 100% compliance for three consecutive months and as needed.	
F 805 SS=D	Food in Form to Meet Individual Needs CFR(s): 483.60(d)(3) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(3) Food prepared in a form designed to meet individual needs.	F 805		5/3/24

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F 805	Continued From page 25 This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that for one (R14) out of one residents reviewed for food the facility failed to prepare food in a form designed to meet the individuals needs. Findings include: Review of R14's clinical record revealed: 6/19/18 - R14 was admitted to the facility. 2/28/24 - A physician's order stated that R14 was on a regular diet with ground meats/mechanical soft texture, regular/thin consistency liquids. (mechanical soft texture are foods that are moist, soft texture, and easily swallowed. Meats are ground or finely cut to equal size no bigger than 1/4 inch). 3/8/24 - A swallow study completed by an outside provider revealed R14 required ground solids and regular liquids. 3/11/24 approximately 12:30 PM - An observation of lunch with R14 revealed whole cauliflower florets. R14's meal ticket stated, "1/2 cup - Ground Parslied Cauliflower." R14 attempted to eat the cauliflower and spit out the stem and stated, "I can't eat this, it's too hard." R14 does not use his dentures and has no other natural teeth. 3/11/24 1:10 PM - During an interview, E16 (RN) confirmed that R14 had whole cauliflower florets and the meal ticket stated it was ground cauliflower. 3/14/24 12:19 PM - During an interview, E22	F 805	1. " R14 is now receiving the correct diet texture consistency. 2. " Any resident with a physician's order for a ground diet has the potential to be affected. 3. " The RCA determined that the cook did not follow the instructions to serve ground cauliflower. " The FSD/designee reeducated cooks on the need to follow meal ticket instructions, and when cauliflower is served, it should be ground. " The FSD/designee will audit 10 meal trays per week to monitor correct consistency and adherence to meal ticket instructions. Audits will be conducted until 100% is achieved for three months. 4. " Audit results will be reported in monthly QA&A meetings until achieving 100% compliance for three consecutive months and as needed.	

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F 805	Continued From page 26 (Food Service Director) was shown the picture of R14's lunch from 3/11/24 and confirmed the cauliflower was not ground. E22 stated that if the vegetable is soft enough, it is acceptable to be given to residents. E22 was informed R14 was unable to consume the cauliflower due to the texture being too hard. E22 stated it was tough to determine which consistency to use (meaning ground or mechanically soft). 3/14/24 12:30 PM - An interview with E23 (Dietician) confirmed that R14 was on a ground diet and he failed his swallow study. E23 confirmed the cauliflower on 3/11/24 was not ground. 3/20/2/24 2:40 PM - Findings reviewed with E1 (NHA), E2 (DON) and E3 (ADON) and E4 (Corporate) during the exit conference.	F 805		
F 812 SS=D	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.	F 812		5/3/24

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F 812	Continued From page 27 §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 and interview it was determined that the facility failed to ensure food was stored, prepared, and served in a manner that prevents food borne illness to the residents. Findings include: 3/11/24 10:34 AM - During the initial tour of the kitchen, there was a partially uncovered container of stuffed peppers in the walk-in refrigerator with the plastic cling film peeled back exposing the food to dirt, debris, and other contaminants. 3/11/24 10:38 AM - During a tour of the kitchen, the reach-in refrigerator contained a plate of unlabeled undated liverwurst. 3/11/24 11:07 AM - An observation of the nourishment refrigerator in the Henlopen hallway revealed a carton of Nutritional Shake that was undated. The instructions on the carton indicate that once opened, any remaining product should be discarded after four (4) days. 3/11/24 11:55 AM - During a tour of the kitchen, the surveyor observed E27 (Dietary Aide) test the sanitizer level of the solution in two red sanitizing buckets. When E27 tested the sanitizing solution, the test strips from each of the two buckets indicated that the level of chemical concentration in the buckets was not at a sufficient level to provide proper sanitization. 3/11/24 1:23 PM - An observation of the nourishment refrigerator in the Sussex hallway	F 812	1. " Food items are now labeled, dated, and covered. " Nutritional Shakes are now being dated with an expiration of 4 days after opening. " Sanitizing buckets now have the proper amount of sanitizer. 2. " All residents have the potential to be affected. 3. " RCA determined staff not following facility□s protocol for operating the kitchen. " The Staff Developer/designee has re-educated kitchen staff on the facility□s protocol for operating the kitchen, which now includes labeling and dating, properly covering food, marking nutritional shakes with expiration dates, and testing sanitizing buckets for the correct level of chemicals. " The system change is the aforementioned items will be incorporated into the facility□s opening and closing checklist. " FSD/designee will conduct weekly kitchen inspections to monitor the facility□s protocol. Audits will be conducted until 100% is achieved for three months.	

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F 812	Continued From page 28 revealed a carton of Nutritional Shake that was dated 3/5/24. The instructions on the carton indicate that once opened, any remaining product should be discarded after four (4) days. 3/15/24 11:43 AM - Findings were confirmed with E1 (NHA). 3/20/24 2:40 PM - Findings reviewed with E1 (NHA), E2 (DON) and E3 (ADON) and E4 (Corporate) during the exit conference.	F 812	4. " Audit results will be reported in monthly QA&A meetings until achieving 100% compliance for three consecutive months and as needed.	
F 919 SS=D	Resident Call System CFR(s): 483.90(g)(1)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from- §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on a random observation and interview, it was determined that the facility failed to ensure that two call bells (room 360) in the facility was functioning properly. Findings include: 3/11/24 approximately 10:15 AM - During a random observation of Room 360 the call bell box on the wall was taken apart and the wires were exposed. Both A and B bed call bells were unable to be plugged in thus were not functioning. Further observation revealed there wasn't any alternate equipment for the residents to call for help.	F 919	1. " Room 360□s call bell is now working. 2. " All residents with a broken call bell have the potential to be affected. All call bells were tested for function. No issues noted. 3. " The RCA determined that the Maintenance Director did not prioritize the critical work order, and the facility failed to provide residents with an alternative means of calling for assistance.	5/3/24

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F 919	Continued From page 29 3/11/24 10:25 AM - During an interview E7 RN confirmed the call bell box was taken apart, the wires were exposed therefore the call bells were unable to be plugged in and there wasn't a bell or any kind of alternate means for the two residents to call for help. E7 was then asked if she knew how long the call bells were not functional? E7 stated she thought last week but wasn't sure. 3/11/24 10:42 AM - During an interview E1 (NHA) and E2 (DON) were asked if they were aware that the call bells in Room 360 were not functioning and the residents did not have a means to call for help. E1 stated "I'll take care of it." 3/11/24 11:00 AM - E1 and E2 were observed carrying two "cow bells" to room 360. 3/11/24 12:41 AM - During an observation, the call bell box was put back together and both call bells were plugged in. This surveyor and E7 tested both and they were functioning properly. 3/15/24 1:50 PM - During an interview, E8 (Maintenance Director) stated that a work order for the broken call bells in room 360 had been submitted electronically on 3/7/24 at 4:57 AM. When asked why it took so long to repair? E8 stated that "I couldn't get to it sooner." and was able to provide this surveyor with a copy of the work order which documented the priority was "critical" but was not repaired until 3/11/24 four days later. 3/20/2/24 2:40 PM - Findings reviewed with E1 (NHA), E2 (DON) and E3 (ADON) and E4 (Corporate) during the exit conference.	F 919	" The system change includes checking the plugs for function when conducting call bell testing. " The Staff Developer/designee re-educated the Maintenance Director on the need to prioritize critical work orders and provide residents with an alternative means of calling for assistance while awaiting repair. " The NHA/designee will conduct weekly audits of critical work orders and monitor the provision of alternative means for residents to call for assistance. Audits will be conducted until 100% is achieved for three months. 4. " Audit results will be reported in monthly QA&A meetings until achieving 100% compliance for three consecutive months and as needed.	

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 085034	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 3/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BREAKWATER VILLAGE	**301 OCEAN VIEW BLVD LEWES, DE**

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 641	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that that for one (R58) out of twenty-one sampled residents the facility failed to ensure the MDS assessment accurately reflected the resident's respiratory status. Findings include: Review of R58's clinical record revealed: 9/12/19 - R58 was admitted to the facility with a diagnosis of obstructive sleep apnea (a sleep disorder characterized by abnormal pauses in breathing or instances of abnormally low breathing during sleep). 3/16/22 - A physician order from E15 (MD) was written in the electronic medical record (MAR) for use of a CPAP machine (used for breathing assistance during sleep) to be applied every night. 6/6/23 - An annual Minimum Data Set (MDS) assessment documented "no" to use of a CPAP machine. 3/20/24 9:11 AM - During an interview E13 (RNAC) confirmed that R58's MDS assessment was inaccurate and stated, "I should have put a yes." 3/20/2/24 2:40 PM - Findings reviewed with E1 (NHA), E2 (DON) and E3 (ADON) and E4 (Corporate) during the exit conference.
F 842	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

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

The above isolated deficiencies pose no actual harm to the residents

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 842	Continued From Page 1

(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-
(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 and interview, it was determined that for two (R255 and R312) out of twenty-one sampled residents, the facility failed to ensure the clinical record contained accurate documentation. Findings include:

1. Review of R255's clinical record revealed:

6/21/23 - R255 was admitted to the facility.

10/10/23 - A facility incident report documented that R255 had a bruise to the left upper arm.

10/10/23 - A nursing progress note documented,"resident noted with left upper arm bruise of unknown origin

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 842	Continued From Page 2 while care was being provided." 3/10/24 11:56 AM - During an interview, E12 (RN) confirmed that the bruising was on the right side, not the left side. 3/20/24 12:34 PM - During an interview, E2 confirmed that the location of the bruising was on the right side. 2. Review of R312's clinical record revealed: 4/21/23 - R312 was admitted to the facility. 3/14/24 11:24 AM - A review of R312's documents in the EMR revealed a psychiatric consult note for R53. 3/15/24 1:16 PM - An interview with E2 (DON) confirmed the psychiatric consult did not belong to R312 and should not have been uploaded to R312's electronic record. 3/20/2/24 2:40 PM - Findings reviewed with E1 (NHA), E2 (DON) and E3 (ADON) and E4 (Corporate) during the exit conference.