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

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

STATE SURVEY REPORT

NAME OF FACILITY: Complete Care At Hillside Llc

DATE SURVEY COMPLETED: January 19, 2022

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 January 10, 2022 to January 19, 2022. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other documentation as indicated. The facility census the first day of the survey was eighty-eight (88). The survey sample size was forty-five (45) residents.	3201 The facility was not able to correct this deficient practice on October 24, October 25 and October 27, 2021.	
3201	Regulations for Skilled and Intermediate Care Facilities	All residents have the potential to be affected by this deficient practice.	
3201.1.0			
3201.1.2	Scope **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 the following: Cross Refer to the CMS 2567-L survey completed January 19, 2022: F609, F623, F656, F684, F760, F773, F803, and F812.	The NHA and DON or designee will review staffing daily to ensure that staffing is at a level of at least 3.28 hours of direct care per resident. The NHA will utilize a HPPD spreadsheet on a daily basis to ensure compliance. Every effort will be made to replace call outs. The NHA will conduct daily audits of staffing HPPD x 4 weeks until 100% compliance is achieved. Then weekly x 3 months until 100% is achieved. The results of these audits will be reviewed by the QAPI Committee who will evaluate data and provide recommendations to obtain and maintain compliance.	
16 Del. Code, 1162			

Provider's Signature [signature] Title NHA Date 2-11-22

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Nursing Staffing:	**(c) By January 1, 2002, the minimum staffing level for nursing services direct caregivers shall not be less than the staffing level required to provide 3.28 hours of direct care per resident per day, subject to Commission recommendation and provided that funds have been appropriated for 3.28 hours of direct care per resident for Medicaid eligible reimbursement.** **Nursing staff must be distributed in order to meet the following minimum weekly shift ratios:** RN/LPN CNA* Day 1 nurse per 15 res. 1 aide per 8 res. Evening 1:23 1:10 Night 1:40 1:20 * or RN, LPN, or NAIT serving as a CNA. (g) The time period for review and determining compliance with the staffing ratios under this chapter shall be one (1) week. A desk review staffing audit was conducted by the State of Delaware, Division of Health Care Quality, Office of Long Term Care Residents Protection on January 27, 2022. The facility was found to be out of compliance with 16 Delaware Code Chapter 11 Nursing Facilities and Similar Facilities. Based on review of facility documentation it		

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	was determined that for three days out of 42 days reviewed, the facility failed to provide staffing at a level of at least 3.28 hours of direct care per resident per day (PPD). Findings include: Review of facility staffing worksheets, completed and signed by the Nursing Home Administrator, revealed the following, but was not limited to: 10/24/2021 PPD = 2.84 10/25/2021 PPD = 3.09 10/27/2021 PPD = 3.26 1/27/2022 at 2:57 PM – In an email correspondence, findings were reviewed with E1 (NHA) regarding the facility's failure to meet staffing requirements. The facility failed to maintain the minimum PPD staffing requirement of 3.28.		

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	085013	A. BUILDING _____ B. WING _____	C 01/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT HILLSIDE LLC	810 SOUTH BROOM STREET WILMINGTON, DE 19805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted at this facility beginning January 10, 2022 through January 19, 2022 by the State of Delaware Division of Health Care Quality, Office of Long Term Care Residents Protection in accordance with 42 CFR 483.73. The facility census the first day of the survey was 88. For the Emergency Preparedness survey, all contracts, operation plans, contact information, and annual emergency drills were up to date. No deficiencies were identified.	E 000		
F 000	INITIAL COMMENTS An unannounced Annual, Complaint and Emergency Preparedness survey was conducted at this facility from January 10, 2022 through January 19, 2022. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census on the first day of the survey was 88. The survey sample totaled 45 residents. Abbreviations/definitions used in this report are as follows: ADON - Assistant Director of Nursing; Antibiotic - medication prescribed to treat a bacterial infection (Bactrim, Keflex); Anticoagulant - medication that work to prevent the coagulation (clotting) of blood; CNA - Certified Nurse's Aide; Coumadin - an anticoagulant medication used to treat or prevent blood clots in the veins, arteries, lungs, or heart;	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/04/2022

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 COVID-19/Coronavirus - a respiratory illness that can be spread person to person; DON - Director of Nursing; eMAR - electronic Medication Administration Record; INR (international normalized ratio) - used to monitor the effectiveness of the anticoagulant Coumadin; FR (French) - refers to the size of a urinary catheter; LPN - Licensed Practical Nurse; MDS (Minimum Data Set) - standardized assessment forms used in nursing homes; ml (milliter) - unit of measure; mg (milligrams) - unit of mass; Neurogenic bladder - a problem in which a person lacks bladder control due to a brain, spinal cord, or nerve condition; NHA - Nursing Home Administrator; NP - Nurse Practitioner; NPE - Nurse Practice Educator; NTI (Narrow Therapeutic Index) - drugs where small differences in dose or blood concentration may lead to dose and blood concentration dependent, serious therapeutic failures or adverse drug reactions; Office of the State Long Term Care Ombudsman - assures that individuals of long term care facilties receive fair treatment; Oxygen saturation - a measure of how much oxygen the blood is carrying in the body; prn - as needed; RN - Registered Nurse; Suprapubic (SP) catheter - a hollow flexible tube inserted into the bladder through a cut in the abdomen to drain urine; Urinary Tract Infection - an infection in any part of your urinary system; Z-guard - a topical ointment to protect the skin.	F 000		

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F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all 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 (R344) out of five residents reviewed for abuse, the facility failed to immediately report an allegation of abuse. Findings include: Review of the facility policy on abuse, last	F 609	R344 no longer resides in the facility. Unable to correct action related to R344. All residents have the potential to be affected by this deficient practice. As of January 19, 2022 there were no other like residents identified. All allegations of	2/25/22

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F 609	Continued From page 3 updated May 2021, indicated, "Anyone in the facility can report suspected abuse to the abuse agency hotline...individuals shall report immediately but not later than two hours...". 12/22/20- The facility reported an allegation of abuse to the State Agency that indicated, "It was reported today that on Sunday 12/20/20 an agency staff RN verbally abused a resident." During an interview on 1/19/22 at 9:26 AM, E14 (CNA) confirmed that the observation of alleged verbal abuse occurred on 12/20/20 and that E14 reported the observation two days later to E15 (former ADON) on 12/22/20. During an interview on 1/19/22 at 11:25 AM, E15 confirmed that E14 (CNA) reported the allegation of abuse on 12/22/20. Findings were reviewed with E1 (NHA) and E2 (DON) on 1/19/22 during the Exit Conference, beginning at 3:20 PM.	F 609	abuse will be reported as required immediately an no later than two hours after the allegation is made. Upon the allegation of verbal abuse being reported to facility management, the facility took immediate action to report to the State Survey Agency and initiate an investigation. E14 who failed to immediately report was reeducated on the requirement of immediate reporting. E14 received disciplinary action/final written warning on 12/22/20 for failure to immediately report. Center staff will be reeducated by the NPE/designee on the requirement of immediate reporting of abuse, neglect, mistreatment and misappropriation of property. Audits on any abuse allegations to check for immediate reporting will be conducted by the NHA/designee weekly x 4 weeks and then monthly x 3 months until 100% compliance is achieved. This audit will include randomly asking staff what is the appropriate timeframe to report an allegation of abuse. The NHA/designee will report to the QAPI Committee on any variances in the data collected. The QAPI Committee will evaluate the data and provide recommendations to obtain and maintain compliance. Goals will consistently be met before the frequency of the audits are decreased.	

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F 623	Continued From page 4	F 623		
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is	F 623		2/25/22

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F 623	Continued From page 5 required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.	F 623		

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F 623	Continued From page 6 §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to ensure that the Ombudsman was notified of a hospital transfer or facility discharge for two (R60 and R92) out of two residents sampled for hospitalization. Findings include: 1. Review of R92's clinical record revealed a lack of evidence that the facility notified the Office of the State Long-Term Care Ombudsman when R92 was transferred to the hospital on 12/29/21. During an interview on 1/13/22 at 12:34 PM, E1 (NHA) confirmed that the facility failed to notify the Ombudsman that R92 was transferred to the hospital on 12/29/21. Findings were reviewed with E1 (NHA) and E2 (DON) on 1/19/22 during the Exit Conference,	F 623	Unable to correct the action for R60 and R92. On 1/14/2022 the Transfer Log was reinitiated for transfers from 1/1/2022 and ongoing as required by the Delaware Health and Social Services, Office of the Secretary, Long-Term Care Ombudsman Program. The NHA/designee will be responsible for ensuring that the Ombudsman is notified as required of a hospital transfer or facility discharge. Audits will be completed monthly x 12 months to review compliance and will continue until 100% compliance is achieved. The NHA will report to the	

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F 623	Continued From page 7 beginning at 3:20 PM. 2. Review of R60's medical records revealed the following: 1/14/22 11:00 AM - A review of R60's nurse progress notes revealed that R60 was transferred to the hospital on the following dates: 8/13/21, 9/16/21, 9/25/21, 10/8/21 and 11/8/21. 1/14/22 11:54 AM - During an interview with E1 (NHA), it was confirmed that the facility had not notified the Office of the State Long-Term Care Ombudsman of hospital transfers since June 2021. Findings were reviewed on 1/19/22 during the Exit Conference, beginning at 3:20 PM, with E1 (NHA), E6 (NPE/Staff Developer), E10 (Regional Clinical Consultant) and E11 (Complete Care Representative).	F 623	QAPI Committee the results of the audit. The QAPI Committee will evaluate the data and provide recommendations to obtain and maintain compliance.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as	F 656		2/25/22

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F 656	Continued From page 8 required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R28) out of 19 resident in the investigative sample, the facility failed to develop comprehensive care plans for identified resident care areas. Findings include: 1a. Review of R28's clinical records revealed the following: 8/12/18 - R28 was admitted to the facility with an indwelling suprapubic (SP) catheter for a	F 656	R28 still resides at the facility and had no negative effect from the missing information on the care plan. Upon discovery of the missing information from the care plan for the suprapubic catheter, the care plan was updated on 1/19/22 to include the nursing care of the suprapubic catheter. Upon discovery of the missing care plan for oxygen use, the care plan was initiated on 1/19/22.	

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F 656	Continued From page 9 diagnosis of neurogenic bladder. 8/13/18 - The care plan for the SP catheter included a goal that R28 would have no signs or symptoms (s/s) of urinary tract infection. Interventions included to monitor for s/s of infection and report to Physician, catheter care twice a day and prn (as needed), keep catheter off of the floor, and provide privacy and comfort. 3/10/19 through 10/27/20 - The following physician's orders were written and initiated related to the care and maintenance of the SP catheter: - 9/19/19 Cleanse SP site daily with soap and water and to Z-Guard with foam drain sponge every night shift. - 10/27/20 "Change supra pubic (sic) catheter with 22 FR (french- the catheter size) and 10 ml (milliliters- how much fluid to use to fill the balloon to hold the catheter in place) prn." R28's comprehensive care plan did not include the nursing care for the SP catheter. 1b. 12/18/20 - R28 had a physician's order for oxygen at 2 liters per minute via nasal cannula and to maintain an oxygen level at 92% or greater every shift. R28's comprehensive care plan did not include the use of oxygen or interventions to maintain an oxygen saturation level at of 92% or greater. 1/18/22 12:50 PM - An interview with E3 (ADON) confirmed there was no care plan for the use of oxygen.	F 656	All residents with a suprapubic catheter or receiving oxygen therapy are at risk for this deficient practice. An audit of residents with suprapubic catheters and receiving oxygen treatment was completed on 2/3/22 to identify like residents and to assure the completion of a comprehensive care plan including the nursing care/maintenance of suprapubic catheter per the physician's order and the oxygen indication of use with the appropriate interventions per the physician's order. Licensed nurses will be reeducated by the NPE/designee on the policy for Care Plans, Comprehensive Person-Centered. Audits of residents with suprapubic catheters and oxygen use will be completed weekly x 4 weeks until 100% compliance is achieved. Audits will then be done monthly x 3 months by the ADON/designee until 100% compliance is achieved. Audits will continue until 100% compliance is achieved. The ADON/designee will report to the QAPI Committee any variances in the data collected. The QAPI Committee will evaluate data and provide recommendations to obtain and maintain compliance.	

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F 656	Continued From page 10 Findings were reviewed on 1/19/22 during the Exit Conference, beginning at 3:20 PM, with E1 (NHA), E6 (NPE/Staff Developer), E10 (Regional Clinical Consultant), and E11 (Complete Care Representative).	F 656		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure that for one (R60) out of two residents reviewed for hospitalizations received medication as ordered by the physician. Findings include: Review of R60's clinical records revealed the following: 10/8/21 - Review of hospital records and nurse progress notes revealed that R60 was diagnosed with a urinary tract infection (UTI) after being sent to the emergency room for an evaluation. R60 returned to the facility with a prescription for the antibiotic medication Keflex. 10/13/21 1:43 PM - Review of nurse progress notes revealed that E9 (RN) received an order from the hospital for R60 to begin a different	F 684	R60 had no negative effect from the delayed first dose of ABT and the facility was not able to correct the action. Review of orders received on 10/13/21 for all current residents showed no other medications were delayed. All residents receiving new medication orders after the pharmacy cut-off time are at risk for this deficient practice. As of 2/9/22 a review of orders showed that no other medications have been delayed. The ADON/designee will review the 24-hour Order Recap Report daily and identify all new orders to ensure that medication is available and administered as ordered. If a medication was not administered and/or is not available, the	2/25/22

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F 684	Continued From page 11 antibiotic, Bactrim, to be given twice a day for seven days due to the Keflex being an ineffective option for treatment of the UTI. 10/13/21 2:50 PM - E9 (RN) transcribed R60's order for Bactrim. 10/13/21 2:55 PM - E9 (RN) discontinued the Keflex order for R60. 10/13/21 9:00 PM - Review of the facility's electronic Medication Administration Record (eMAR) revealed that R60 did not receive the first dose of the new antibiotic Bactrim. 10/13/21 10:28 PM - Review of nurse progress notes revealed that the Bactrim was not available, and the pharmacy was notified, however, E8 (LPN) did not document if the Physician or designee was made aware that the medication was not available. 10/14/21 at 4:35 AM - Review of the pharmacy delivery logs revealed that R60's Bactrim was received by the facility. 10/14/21 9:00 AM - Review of the facility's eMAR revealed that R60 received the first dose of Bactrim, approximately 12 hours later than it should have been given; R60 missed one dose of Bactrim. 1/17/22 12:30 PM - Review of the facility's pharmacy procedures revealed that when a medication was not available, staff should notify the Physician or designee, or request that the medication be sent immediately (STAT) from the pharmacy.	F 684	physician will be notified per policy. Licensed nurses will be reeducated by the NPE/designee on the facility's Pharmacy Procedure that when a medication is not available, staff should notify the physician or designee, or request that the medication be sent immediately (STAT) from the pharmacy. Audits of residents with new medication orders (Order Recap Report) will be reviewed daily by the ADON/designee to identify if new medication orders are available and administered as ordered within a 24 hour period daily x 4 weeks until 100% compliance is achieved, then weekly x 3 months until 100% compliance is achieved. The ADON/designee will report to the QAPI Committee any variances in the data collected. The QAPI Committee will evaluate the data and provide recommendations to obtain and maintain compliance.	

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F 684	Continued From page 12 1/18/22 1:46 PM - Review of pharmacy information provided by E1 (NHA) revealed that no STAT requests were made by the facility between 10/12/21-10/14/21. 1/18/22 3:22 PM - Interview with E6 (Infection Control Nurse/Staff Developer) revealed that she had been tracking R60's infection, but that she was unaware that R60 did not receive the first dose of the Bactrim due on 10/13/21. E6 confirmed that the expectation of staff was that when a medication was not available, the Provider (Physician or designee) needed to be made aware. E6 also confirmed that Bactrim was not available in the facility's back-up medication supply. 1/18/22 3:48 PM - Interview with E8 (LPN) revealed that she was uncertain if she notified the Provider when R60's Bactrim was not available. 1/19/22 12:47 PM - During an interview with E12 (Nurse Practitioner), E12 confirmed that the expectation was that when a medication was not available, the nurses notify her or another Provider to determine what to do next. Findings were reviewed on 1/19/22 during the Exit Conference, beginning at 3:20 PM, with E1 (NHA), E6 (NPE/Staff Developer), E10 (Regional Clinical Consultant), and E11 (Complete Care Representative).	F 684		
F 760 SS=E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors.	F 760		2/25/22

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F 760	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on interview and review of the clinical record and the facility's policy and procedure, it was determined that for one (R343) out of two sampled residents for Coumadin medication review, the facility failed to ensure that R343's INR (international normalized ratio) lab level was monitored between 11/2/21 to 11/16/21 while receiving Coumadin (a blood thinner) 6 mg daily, a significant medication with a Narrow Therapeutic Index (NTI). Findings include: 5/21 (revised) - The facility's Coumadin Anticoagulant Therapy policy and procedure stated, "... Policy: All residents requiring Coumadin administration will have a ... INR drawn as ordered by the physician to determine effectiveness of therapy and subsequent dosages. Licensed nurses will monitor the required lab work completion ... Procedure: 1. Obtain physician's order for ... INR drawing ... 2. Post ... INR results on flow sheet or EHR (electronic health record), indicating date... 4. Prior to administering the dose of Coumadin nurse will be required to check and document date and results of last INR for current dose of Coumadin...". Review of R343's clinical record revealed: 11/2/21 - R343's History and Physical documented "... Continue patient on Coumadin follow-up INR...". 11/3/21 - A progress note documented "... Labs: 11/1/21 INR 3.4 ... continue with Coumadin, continue monitor INRs...".	F 760	R343 was discharged from the facility on 11//7/21 and had no negative effect from the missing lab monitoring. The facility was unable to correct the action for R343. Review of current residents in the facility on 1/18/22 receiving Coumadin therapy found current orders for PT/INR monitoring in place. Residents receiving Coumadin Anticoagulant Therapy are at risk for this deficient practice. This deficient practice occurred due to the facility's failure to ensure that the INR lab level was monitored. All residents on coumadin therapy will have a standing order for PT/INR lab work to be done per the physician order. The ADON/designee will verify that the lab result was obtained and MD notified of results. Coumadin orders on the eMAR will have supplementary documentation added for nurses to document the current PT/INR result prior to the coumadin administration. Licensed nurses will be reeducated by NPE/designee on Policy CC-15 Coumadin Anticoagulant Therapy. Audits of residents receiving Coumadin therapy will be completed by the ADON/designee for current PT/INR orders weekly x 4 weeks until 100% compliance is achieved and then monthly	

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F 760	Continued From page 14 From 11/2/21 through 11/16/21 - The November 2021 electronic Medication Administration Record (eMAR) documented that nursing staff administered Coumadin 6 mg to R343 every evening shift, a total of 15 administrations. R343's clinical record lacked evidence that nursing staff were checking and documenting R343's last INR lab result before the administration of the current dose of Coumadin. Review of R343's clinical record (both electronic and hard chart) lacked evidence that her INR lab level was monitored from 11/2/21 through 11/16/21. 1/19/22 at 9:44 AM - During an interview, E13 (Physician) acknowledged that R343's INR lab level was not monitored from 11/2/21 through 11/16/21. 1/19/22 at 3:20 PM - Findings were reviewed during the Exit Conference with E1 (NHA), E6 (NPE/Staff Developer), E10 (Regional Clinical Consultant), and E11 (Complete Care Representative). The facility failed to ensure R343's INR lab level was monitored from 11/2/22 through 11/16/22 while receiving Coumadin.	F 760	x 3 months until 100% compliance is achieved. The ADON/designee will report to the QAPI Committee any variances in the data collected. The QAPI Committee will evaluate the data and provide recommendations to obtain and maintain compliance.	
F 773 SS=D	Lab Srvcs Physician Order/Notify of Results CFR(s): 483.50(a)(2)(i)(ii) §483.50(a)(2) The facility must- (i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws.	F 773		2/25/22

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F 773	Continued From page 15 (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. This REQUIREMENT is not met as evidenced by: Based on interview and review of the clinical record and the facility's policy and procedure, it was determined that for one (R80) out of two residents sampled for Coumadin medication review, the facility failed to ensure that R80's 1/3/22 lab result was received and reviewed by the physician. Findings include: 5/21 (revised) - The facility's Coumadin Anticoagulant Therapy policy and procedure stated, "... Policy: All residents requiring Coumadin administration will have a ... INR drawn as ordered by the physician to determine effectiveness of therapy and subsequent dosages. Licensed nurses will monitor the required lab work completion ... Procedure: 1. Obtain physician's order for ... INR drawing ... 2. Post ... INR results on flow sheet or EHR (electronic health record), indicating date ... 4. Prior to administering the dose of Coumadin nurse will be required to check and document date and results of last INR for current dose of Coumadin...". Review of R80's clinical record revealed: 1/3/22 - A physician order documented, "... INR one time only until 1/3/2022...". 1/3/22 - The January 2022 electronic Medication	F 773	R80 had no negative effect from the delay in receiving/reviewing the lab result of 1/3/22. The facility was not able to correct the action for R80. Upon discovery of the delay in receiving the lab result, the result was obtained and reviewed by medical staff. Review of residents in the facility on 1/18/22 at the time of discovery showed all labs ordered to date were received and reviewed by medical staff. The ADON/designee will review daily labs ordered versus lab results received. Licensed nurses will be educated by the NPE/designee on facility process to review labs ordered for the day and obtain the results for review by the medical staff. Audits of labs ordered, and results received will be completed by the ADON/designee weekly x 4 weeks until 100% compliance is achieved, and then monthly x 3 months until 100% compliance is achieved. The ADON/designee will report to the QAPI Committee any variances in the data collected. The QAPI Committee will	

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F 773	Continued From page 16 Administration Record (eMAR) revealed that a facility nurse signed off that R80's INR lab draw was completed. 1/18/22 at 1:15 PM - During an interview, E4 (RN) was asked for the 1/3/22 INR lab result. E4 could not locate the lab result and immediately called the lab company. E4 informed the Surveyor that the lab company sent R80's lab result to another (unidentified) account. E4 received a faxed copy of R80's 1/3/22 lab result 15 days later, which revealed an INR level of 1.47. 1/19/22 at 3:20 PM - Findings were reviewed during the Exit Conference with E1 (NHA), E6 (NPE/Staff Developer), E10 (Regional Clinical Consultant), and E11 (Complete Care Representative). The facility failed to ensure R80's 1/3/22 INR lab result was received and reviewed by the physician.	F 773	evaluate the data and provide recommendations to obtain and maintain compliance.	
F 808 SS=D	Therapeutic Diet Prescribed by Physician CFR(s): 483.60(e)(1)(2) §483.60(e) Therapeutic Diets §483.60(e)(1) Therapeutic diets must be prescribed by the attending physician. §483.60(e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law. This REQUIREMENT is not met as evidenced by: Based on observations, clinical record review and interviews, it was determined that the facility	F 808	R79 dietary profile has been reviewed and updated to assure that foods	2/25/22

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F 808	Continued From page 17 failed to ensure that the physician's order for one resident (R79) was followed during a random dining observation. Findings include: Review of R79's clinical record revealed the following: 11/23/21- R79 was originally admitted to the facility. 11/26/21 - The Admission MDS Assessment documented that R79 was independent in daily decision making. 12/17/21 - A physician's order was written for regular, low lactose and low fiber diet and to avoid diary such as milk and ice cream. 1/10/22 12:45 PM - During a random dining observation, R79's lunch tray and comparison of the meal ticket (a form used by the facility in which residents check their meal selection) did not match. R79's meal ticket stated "...NO DIARY/lactose intolerance, LOW FIBER...NO ENTREE, GIVE instead meat sandwich (no cheese)...G ve bag of chips." The tray did not contain the sandwich with chips and incorrectly contained an entree of fettuccini alfredo (contains butter, heavy cream and parmesan cheese which are all diary products). 1/13/22 1 PM - An interview with E7 (RD) confirmed that R79 should have been provided a sandwich and the bag of chips instead of the entree. 1/19/22 11:20 AM - An interview with E5 (FSD) confirmed the Alfredo sauce served to R79 contained diary products.	F 808	containing lactose are excluded. All residents on a low-lactose diet are at risk for this deficient practice. This deficient practice occurred due to tray-line staff not adhering to the MealTracker for R79. An audit of residents dietary profiles in the MealTracker system was completed to assure that any food intolerances are addressed, and those foods removed from those residents' profile. Dining Department Supervisor and staff will be educated by the RD on tray ticket accuracy. RD or designee will conduct weekly audits with a goal of consistently meeting 100% compliance x 3 months to ensure no resident receives a food which they are unable to tolerate. These audits will continue until 100% compliance is received. Audits will include all meals and all days of the week. The Dining Department Supervisor or designee will report to the QAPI Committee any variances in the data collected. The QAPI Committee will evaluate the data and provide recommendations to obtain and maintain compliance.	

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F 808	Continued From page 18 The facility failed to follow R79's physician prescribed diet of low lactose diet to include avoidance of dairy products and the facility failed to provide the sandwich and chips instead of fettuccini alfredo for lunch on 1/10/22. Findings were reviewed on 1/19/22 during the Exit Conference, beginning at 3:20 PM, with E1 (NHA), E6 (NPE/Staff Developer), E10 (Regional Clinical Consultant), and E11 (Complete Care Representative).	F 808		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, it was determined that the facility failed to ensure that	F 812	The paper towel dispenser has been moved >3 feet away from the sink's	2/25/22

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F 812	Continued From page 19 food was stored, prepared, and served in a sanitary manner. Findings include: The following were observed during the kitchen tour on 1/10/22 from 9:35 AM to 10:15 AM: - The paper towel dispenser at the cooking area hand sink had clean paper towels dispensing into the hand washing splash zone. The splash zone is an area around a sink in which contamination could occur CMS identifies it as 3 feet apart; - The fume hood was greasy; - The hand sink by the dishwashing area was inaccessible. Findings were reviewed and confirmed by E5 (FSD) on 1/10/22 at approximately 10:15 AM. Findings were reviewed on 1/19/22 during the Exit Conference, beginning at 3:20 PM, with E1 (NHA), E6 (NPE/Staff Developer), E10 (Regional Clinical Consultant), and E11 (Complete Care Representative).	F 812	splash zone. The fume hood has been cleaned and serviced. The area around the hand sink by the dishwashing area has been cleared to assure it is accessible. An audit of hand sinks and paper towel dispensers has been completed to assure that no additional concerns exist. The fume hood cleaning schedule has been shared with Dining services staff and clearly posted. Dining Supervisor will be educated regarding food safety and sanitation procedures including the paper towel dispenser, the importance of no grease on the fume hood and hand sink accessibility. The RD, Dining Supervisor and/or designee will conduct weekly audits, with the goal of 100% consistent compliance, x 3 months to ensure that hand sinks are easily accessible, paper towels are not being dispensed in to splash zones, and fume hoods are clean and free from grease. Audits will continue until 100% compliance is achieved. The Dining Supervisor/designee will report to the QAPI Committee any variances in the data collected. The QAPI Committee will evaluate the data and provide recommendations to obtain and maintain compliance.	