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: Complete Care at Hillside LLC

DATE SURVEY COMPLETED: February 01, 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. A Recertification and Complaint survey was conducted by Healthcare Management Solutions, LLC, on behalf of the State of Delaware, Department of Health and Social Services, Division of Health Care Quality. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B. Survey Dates: 01/29/24 - 02/01/24 Survey Census: 98 Sample Size: 40 Supplemental Residents: 4	3201.1.2 Cross Refer to the CMS 2567-L survey completed February 1, 2024: F557, F656, F689, F695, F812 and F880 for Plan for Correction of Deficiencies.	3/6/2024
3201	**Regulations for Skilled and Intermediate Care Nursing 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:**		

Provider's Signature Ruth A Agyei Title LNHA Date 3-7-2024

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	Cross Refer to the CMS 2567-L survey completed February 1, 2024: F558, F656, F689, F695, F812 and F880.		

Provider's Signature Ruth S Dow Title LNHA Date 3-7-2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085013	A. BUILDING _____ B. WING _____	C 02/01/2024

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 A Recertification, Complaint, and Emergency Preparedness survey was conducted by Healthcare Management Solutions, LLC, on behalf of the State of Delaware, Department of Health and Social Services, Division of Health Care Quality on 01/29/24 through 02/01/24. The facility was found to be in substantial compliance with 42 CFR 483 subpart B.	E 000		
F 000	INITIAL COMMENTS A Recertification and Complaint survey was conducted by Healthcare Management Solutions, LLC, on behalf of the State of Delaware, Department of Health and Social Services, Division of Health Care Quality. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B. Survey Dates: 01/29/24 - 02/01/24 Survey Census: 98 Sample Size: 40 Supplemental Residents: 4	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and facility policy review, the facility failed to ensure call lights were within reach for three residents (Residents (R) 45, 55, and 34) out of a sample of	F 558	R45, R55 and R34's call bells were placed within reach. All residents have the potential to be	3/6/24

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

Electronically Signed | 02/17/2024

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F 558	Continued From page 1 40 residents reviewed for accommodation of needs and preferences. Specifically, the facility failed to ensure residents had access to their call lights to best assist the resident in maintaining and/or achieving their independent functioning, dignity, and well-being to the extent possible. Findings include: 1. Review of R45's "Face Sheet," located under the "Profile" tab of the electronic medical record (EMR), revealed R45 was admitted to the facility on 11/17/16 with diagnoses which included hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting right dominant side, hypertensive heart and chronic kidney disease without heart failure, and epilepsy. Review of R45's Annual "Minimum Data Set (MDS)," with an Assessment Reference Date (ARD) of 12/07/23, located under the "RAI (Resident Assessment Instrument)" tab, showed a "Brief Interview for Mental Status (BIMS)" score of 00 out of 15, indicating severe cognitive impairment. Nursing notes on 01/23/24 documented the resident as alert and oriented to person and place. R45 was assessed to have upper and lower extremity impairment on one side and was dependent on staff for transfers. R45 was observed on 01/29/24 at 10:36 AM in bed with the call light button looped around the call system on the wall behind the resident, out of reach. She stated that she did not know where the call light button was. R45 was observed on 01/31/24 at 9:10 AM in bed. The call light button was stuck underneath the left side of the bed rail system and the	F 558	affected by this deficient practice. An audit was completed on 2/2/2024 to determine if any other resident was affected. The audit revealed that no other resident was affected. The root cause of this deficient practice was the facility failed to ensure that call bells were within reach of each resident. Staff Development Coordinator (SDC) and/or designee will educate staff on the importance of call bell accessibility to best assist the resident in maintaining and/or achieving their independent functioning, dignity and well-being to the extent possible. A Call Bell Within Reach Audit will be completed daily, by floor, by the DON and/or designee until the facility consistently reaches 100% success over 3 consecutive evaluations. Then, the audit tool will be completed three times a week until the facility reaches 100% success at 3 consecutive evaluations. Then, the audit tool will be completed once a week until the facility consistently reaches 100% success over 3 consecutive evaluations. Finally, the facility will measure one more time a month later. If the facility reaches 100% success, the facility can conclude that it has successfully addressed the problem.	

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F 558	Continued From page 2 mattress, out of reach of the resident. On 01/31/24 at 9:11 AM, Licensed Practical Nurse (LPN) 13 observed the call light button for R45, pulled it through the bed rail system, where it lodged, and clipped it to the resident. LPN13 stated that the call light button should be in reach of the resident and confirmed it had not been accessible for R45. 2. Review of R55's "Face Sheet," located under the "Profile" tab of the electronic medical record (EMR), revealed R45 was admitted to the facility on 06/06/19 with diagnoses which included hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, dysphagia, and diabetes mellitus. Review of R55's Quarterly "Minimum Data Set (MDS)," with an Assessment Reference Date (ARD) of 01/03/24, located under the "RAI (Resident Assessment Instrument)" tab, showed a "Brief Interview for Mental Status (BIMS)" score of 14 out of 15, indicating cognitively intact. R55 was assessed to require partial/moderate assistance for mobility to roll left and right. R55 was observed on 01/29/24 at 10:59 AM in bed with the call light button hanging down the side of the bed out of reach of the resident. R55 was observed on 01/30/24 at 2:05 PM in bed, leaning on his right side. The call light button was observed hanging down over the left side of the bed out of reach of the resident. R55 was observed on 01/31/24 at 8:50 AM in bed, leaning on his right side. The call light button was observed tucked down on the left side of the	F 558		

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F 558	Continued From page 3	F 558		

bed between the mattress and the bed rail. The resident pulled on his bed control but could not reach his call light button.

3. Review of R34's "Face Sheet," located under the "Profile" tab of the electronic medical record (EMR), revealed R34 was admitted to the facility on 05/16/19 with diagnoses which included hemiplegia and hemiparesis following cerebral infarction unspecified cerebrovascular disease affecting right dominant side, diabetes mellitus, and dysphagia

Review of R34's Quarterly Annual "Minimum Data Set (MDS)," with an Assessment Reference Date (ARD) of 11/16/23, located under the "RAI (Resident Assessment Instrument)" tab, showed a "Brief Interview for Mental Status (BIMS)" score of 9 out of 15, indicating moderate cognitive impairment. R34 was assessed to have upper and lower extremity impairment on one side and was dependent on staff for transfers.

R34 was observed on 01/29/24 at 10:57 AM in bed with the call light button hanging down the right side of the resident's bed out of reach.

R34 was observed on 01/31/24 at 8:50 AM in bed with the call light button hanging down on the right side of the bed out of reach of the resident.

During a concurrent interview on 01/31/24 at 8:55 AM with Certified Nursing Assistants (CNA) 6 and 9, they stated that call light buttons should always be in close proximity to each facility resident so they could always reach them. CNA6 and CNA9 said that they could use touch pad call lights if they were needed.

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F 558	Continued From page 4 During an interview on 01/31/24 at 9:03 AM, LPN11 said that the aides should keep the call light buttons in easy access for all residents. LPN11 observed R55 and R34 and confirmed the call lights were not accessible to the residents. During an interview on 01/31/24 at 12:15 PM, the Director of Nursing stated that call lights should always be within easy reach of residents. Director of Nursing confirmed that call lights tucked between the bed rail and a resident mattress would not be considered accessible to residents. Review of the 03/14/23 policy titled, "Call Lights: Accessibility and Timely Response," revealed, "The purpose of this policy is to assure the facility is adequately equipped with a call light at each residents' bedside, toilet, and bathing facility to allow residents to call for assistance. Call lights will directly relay to a staff member or centralized location to ensure appropriate response . . . Staff will encourage the call light is within reach of resident and secured, as needed . . ."	F 558		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain	F 656		3/6/24

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F 656	Continued From page 5 or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, review of the Resident Assessment Instrument (RAI) manual, and staff interviews, the facility failed to develop and implement a person-centered comprehensive plan of care with	F 656	R87's care plan was updated to address the Post Traumatic Stress Disorder (PTSD). Residents with PTSD have the potential to	

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F 656	Continued From page 6 measurable goals and plans for one of 40 sampled residents (Resident (R) R87) reviewed for care plans. Specifically, R87 did not have a "Care Plan" to address Post Traumatic Stress Disorder (PTSD). Findings include: Review of R87's "Admission Record," located in the electronic medical record (EMR) under the "Profile" tab, revealed an admission date of 01/05/24 with admitting diagnoses of post-traumatic stress disorder (PTSD), diabetes, and other disorders of gait and mobility. Review of R87's admission "Minimum Data Set (MDS)," with an Assessment Reference Date (ARD) of 01/11/24 and located under the "MDS" tab of the EMR, revealed R87 had a "Brief Interview of Mental Status (BIMS)" score of 15 out of 15, indicating R87 was cognitively intact. Review of R87's "Care Plan," located in the EMR under the "Care Plan" tab, revealed there was not a care plan for PTSD. On 01/29/24 at 1:47 PM, R87 stated he suffered from PTSD. R87 stated, "I have PTSD from the Gulf War. I take medication for this to control my anxiety." R87 stated, "The war was terrible. I was in the Army." During an interview on 01/30/24 at 1:35 PM, the Assistant Director of Nursing (ADON) stated, "I do all the care plans for residents." When asked who does the care plans if she was on vacation, the ADON stated, "Honestly, no one. I do the best I can." The ADON was asked if she knew R87 had PTSD. She stated, "I do not remember." The	F 656	be affected. An audit of care plans of residents with a diagnosis of PTSD was completed. The root cause of the deficient practice was that the Social Services Director (SSD) failed to generate a customized care plan for R87. The SDC provided education to the SSD regarding the development and customization of the PTSD care plan. Residents admitted with a diagnosis of PTSD will be identified upon admission by the inter-disciplinary team (IDT) at the daily clinical meeting and a care plan generated if applicable. A PTSD Care Plan Audit tool will be completed daily by the DON and/or designee until the facility consistently reaches 100% success over 3 consecutive evaluations. Then, the audit tool will be completed three times a week until the facility reaches 100% success at 3 consecutive evaluations. Then, the audit tool will be completed once a week until the facility consistently reaches 100% success over 3 consecutive evaluations. Finally, the facility will measure one more time a month later. If the facility reaches 100% success, the facility can conclude that it has successfully addressed the problem.	

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F 656	Continued From page 7 ADON was asked if R87's PTSD should have been care planned since it was on the admitting diagnosis from 01/05/24. The ADON confirmed, "Yes." During an interview on 01/30/24 at 2:03 PM, the Director of Nursing (DON) stated, "I know what the ADON told you, but I also do care plans. We do chart review every morning and [R87]'s care plan for PTSD should have been picked up." Interview with Certified Nursing Assistant (CNA) 2 on 01/30/24 at 2:34 PM revealed, "I do not know of any triggers for [R87]. I do not see the care plan. I did not know [R87] had PTSD." Review of the "Minimum Data Set (MDS) 3.0 RAI Manual," dated 10/19, indicated, ". . . Care Area Assessment (CAA) Process. This process is designed to assist the assessor to systematically interpret the information recorded on the MDS . . . The CAA process helps the clinician to focus on key issues identified during the assessment process so that decisions as to whether and how to intervene can be explored with the resident . . . Specific components of the CAA process include: - Care Area Triggers (CATs) are specific resident responses for one or a combination of MDS elements. The triggers identify residents who have or are at risk for developing specific functional problems and require further assessment . . . The MDS does not constitute a comprehensive assessment. Rather, it is a preliminary assessment to identify potential resident problems, strengths, and preferences. Care Areas are triggered by MDS item responses that indicate the need for additional assessment based on problem identification, known as "triggered care areas," which form a critical link	F 656		

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F 656	Continued From page 8 between the MDS and decisions about care planning . . . " Review of the facility policy "Care Plans, Comprehensive Person-Centered," stated, "A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident . . . Areas of concern that are identified during the resident assessment will be evaluated before interventions are added to the care plan . . . Care plan interventions are chosen only after careful data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making . . ."	F 656		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to accurately assess one resident after an unwitnessed fall and failed to put additional interventions in place to prevent future falls for one of three (Resident 10 (R10)) sampled residents reviewed for falls.	F 689	R10's care plan was updated to include an intervention for R10's last fall. If another fall occurs, a new intervention will be put in place. Residents with falls have the potential to be affected by this deficient practice. An	3/6/24

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F 689	Continued From page 9 Findings include: Review of R10's "Diagnosis" tab of the electronic medical record (EMR) revealed R10 was admitted to the facility on 03/15/23 with diagnoses that included dementia, psychotic disturbance, mood disturbance, anxiety, and glaucoma. Review of R10's quarterly "Minimum Data Set (MDS)," located under the "MDS" tab of the EMR and with an Assessment Reference Date (ARD) of 12/19/23, revealed R10 was identified as moderately cognitively impaired, having functional limitations on one side of her upper and lower extremities, frequently incontinent of urine, and always incontinent of bowel. Review of R10's Plan of Care (POC), located under the "POC" tab of the EMR and with a revision date of 05/24/23, revealed the resident was dependent for activities of daily living in bathing, grooming, personal hygiene, dressing, bed mobility, transfers, locomotion, and toileting. R10's plan of care for falls, with a revision date of 05/24/23, recorded she would have no falls with injuries in the next 90 days. The interventions included bilateral bolsters to bed, with an initiation date of 05/18/23; to encourage to wear shoes or socks with nonskid soles with ambulating, with an initiation date of 03/16/23; to monitor for and assist toileting needs, with an initiation date of 03/16/23; and to place the call light within reach, initiated on 03/16/23. Review of R10's "Nursing Progress Note," dated 05/13/23 at 1:40 AM and located under the "Progress Notes" tab of the EMR, revealed the nurse was called to the resident's room by the certified nursing assistant, and the resident was	F 689	audit of recent falls (past 3 months) was completed and revealed that care plans had been updated with new interventions or continued interventions. The root cause of this deficient practice is that the fall risk assessment done by LPN14 was inaccurately marked and did not include resident having psychiatric or cognitive conditions. LPN14 also did not mark that the resident had problems with mobility, standing and sitting. R87's incident report did indicate a continued intervention and this continued intervention was not noted on the care plan. The SDC will educate RN's and LPN's on the accurate completion of the fall assessment and the need to update the care plan with an intervention. A Care Plan Audit tool will be completed daily by the DON and/or designee to ensure that an accurate fall assessment is completed and the care plan is updated as indicated. This audit will be completed until the facility consistently reaches 100% success over 3 consecutive evaluations. Then, the audit tool will be completed three times a week until the facility reaches 100% success at 3 consecutive evaluations. Then, the audit tool will be completed once a week until the facility consistently reaches 100% success over 3 consecutive evaluations. Finally, the facility will measure one more time a month later. If the facility reaches 100% success, the facility can conclude that it has successfully addressed the problem.	

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F 689	Continued From page 10	F 689		

found on the floor on her back, under her bed, using the bed remote, and the bed was being raised to the high position. The note recorded the nurse took the remote from R10 and assisted her back to bed after being assessed for injury. The note was signed by Registered Nurse (RN) 15. According to the nursing notes, R10 was assessed as having no visible injuries but did complain of right hip and shoulder pain. X rays of the right hip and shoulder were obtained and showed R10 had no injury to the right hip or shoulder related to the fall.

Review of R10's "Fall Risk Assessment," dated 05/13/23 at 4:53 AM and located under the "Assessment" tab of the EMR, revealed the resident was assessed for falls after this fall and was determined to be at moderate risk for falls. The assessment recorded the resident attempted to get out of bed at times.

Review of R10's "General Progress Note," located in the "Progress Notes" tab of the EMR and dated 05/18/23 at 6:04 PM, revealed bilateral bolsters were placed on the resident's bed and the intervention was added to the fall plan of care.

Review of R10's "Progress Note," located under the "Progress Notes" tab of the EMR, dated 12/22/23 a t3:29 AM, and written by Licensed Practical Nurse (LPN) 14 revealed the resident was found on the floor, on her back, and under her bed. According to the note, R10 denied hitting her head, denied pain, and was able to move all her extremities. According to the note, R10 was assisted back to bed by the nurse and the nursing assistant.

On 01/31/24 at 3:33 PM, LPN 14 was interviewed

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via telephone. LPN 14 stated she was passing by the room and found R10 on the floor. She stated the resident was in bed with the bolsters in place prior to her fall. LPN 14 stated staff completed checks on the residents at least every two hours. LPN 14 stated the resident had been checked on less than an hour prior to the fall on 12/22/23 and was in bed. She stated she routinely worked the 11:00 PM to 7:30 AM shift on the unit, and R10 usually slept through the night, but she did have a habit of stating she wanted to go home. LPN 14 stated when she found R10 on the floor, the resident stated she was getting up to go somewhere.

Review of the "Fall Risk Assessment," located in the "Assessment" tab of the EMR, revealed there was a fall risk assessment completed by LPN 14 on 12/22/23 at 1:45 AM. Review of the assessment revealed LPN 14 wrote R10 was at low risk for falls and inaccurately marked the resident as not having any psychiatric or cognitive conditions. The assessment asked if the resident had any problems with mobility, standing, and sitting, and LPN 14 marked the resident did not.

On 01/31/24 at 3:07 PM, the Director of Nursing (DON) was interviewed about the fall. The DON verified the fall on 12/22/23 occurred the same way as the fall on 05/13/23 and stated R10 had said she was getting up to go somewhere. The DON stated she did not change any of the interventions to prevent future falls because she felt the fall was attributed to the low air loss mattress being slick, and she felt the benefits outweighed the risks; therefore, she did not add any additional interventions. The DON reviewed the Fall Risk Assessment dated 12/22/23 and confirmed the assessment was not accurate.

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F 689	Continued From page 12 Review of the facility's "Fall Prevention Program" policy, with a revised date of 09/05/23, revealed, ". . . When any resident experiences a fall, the facility will complete a post-fall assessment and review the resident's care plan and update as indicated . . ."	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the facility failed to obtain a physician's order for the use of oxygen for one of four residents (Resident (R) 2) reviewed for oxygen therapy out of a total sample of 40 residents. Findings include: Review of R2's "Face Sheet," located under the "Profile" tab of the electronic medical record (EMR), revealed R2 was admitted to the facility on 11/28/18 with diagnoses which included chronic obstructive pulmonary disease, cervical disc disorder with myelopathy, chronic diastolic (congestive) heart failure, and acute and chronic respiratory failure with hypoxia.	F 695	A physician order for R2's oxygen was obtained on 1/30/2024. The order was for 3 liters per minute (LPM). An audit was completed on 1/30/2024 for residents receiving oxygen to ensure that a physician order was in place and the proper LPM were being delivered. The root cause of this deficient practice is that there was no physician order in place for the delivery of oxygen or the LPM. The SDC will educate RN's and LPN's on the need to obtain a physician order for oxygen and the the order must specify LPM.	3/6/24

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F 695	Continued From page 13 Review of R2's Quarterly "Minimum Data Set (MDS)," with an Assessment Reference Date (ARD) of 12/27/23, located under the "RAI (Resident Assessment Instrument)" tab, showed a "Brief Interview for Mental Status (BIMS)" score of 15 out of 15, indicating R2 was cognitively intact. R2 was documented to be on oxygen while a resident. Review of R2's EMR under the "Orders" tab revealed a 06/27/23 physician order for "O2 [oxygen] Sats[saturation]/Pulse" every shift. Review of R2's EMR under the "Orders" tab revealed a 06/27/23 physician order for "Oxygen tubing change weekly Label each component with date and initials." Review of R2's EMR under the "Orders" tab revealed a 06/28/23 physician order to "ensure foam padding is on oxygen tubing for ear protection" every shift. Review of R2's EMR under the "Orders" tab revealed there was no physician order for the actual oxygen, liters per minute, or expected parameters regarding the administration of oxygen. Review of R2's "Care Plan," initiated on 06/28/23 and located in the EMR under the "Care Plan" tab, included oxygen therapy related to congestive heart failure and ineffective gas exchange. Interventions included to give medications as ordered by physician and to monitor/document side effects and effectiveness. During an observation on 01/29/24 at 4:10 PM,	F 695	The DON and/or designee will audit physician orders for residents receiving oxygen to ensure that the order exists and that it specifies LPM. The audit will include comparing the physician's order to the delivery of oxygen LPM to the resident. This audit will be completed daily until the facility consistently reaches 100% success over 3 consecutive evaluations. Then, the audit tool will be completed three times a week until the facility reaches 100% success at 3 consecutive evaluations. Then, the audit tool will be completed once a week until the facility consistently reaches 100% success over 3 consecutive evaluations. Finally, the facility will measure one more time a month later. If the facility reaches 100% success, the facility can conclude that it has successfully addressed the problem.	

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F 695	Continued From page 14 R2 was observed using oxygen from the room concentrator while in bed. The oxygen concentrator was set at 2.5 LPM (liters per minute). During an observation on 01/30/24 at 2:10 PM, R2 was observed in his bed with the oxygen concentrator in use, set at 3 LPM. R2 stated that he had been on oxygen for a very long time, all day, and his oxygen was always set at 3 LPM. Oxygen was again observed in use on 01/30/24 at 6:14 PM. During a concurrent interview on 01/31/24 at 8:55 AM with Certified Nursing Assistants (CNA) 6 and 9, they stated that only nurses managed resident oxygen. They said that the CNAs could remove the oxygen cannula while cleaning up the resident, but they could not adjust the oxygen LPM, or anything else. If there was a problem, they would inform a nurse. CNA6 and CNA9 both agreed that R2 was regularly on oxygen. During an interview on 01/31/24 at 9:03 AM, Licensed Practical Nurse (LPN) 11 said that nurses did all the oxygen monitoring at the facility. LPN11 confirmed that R2 was on oxygen, and upon observation confirmed that he was currently on 3 LPM. LPN11 reviewed the physician orders for R2 and said that there were no current orders in place for oxygen. LPN11 said that somehow the physician order for oxygen must have not been placed back on the resident's chart after a hospital discharge. During an interview on 01/31/24 at 12:15 PM, the Director of Nursing said that R2 was "definitely on oxygen." The Director of Nursing confirmed that there should have been a physician order in place	F 695		

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F 695	Continued From page 15 for the use of oxygen for R2 and was not sure why it was not in place. The Director of Nursing said that the physician order might not have been put back on his chart after a hospital visit and said that the order would be corrected. Review of the facility's 2022 policy titled, "Oxygen Administration," revealed, "Oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the resident's goals and preferences . . . 1. Oxygen is administered under orders of a physician, except in the case of an emergency . . ."	F 695		
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	F 812		3/6/24

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F 812	Continued From page 16 by: Based on observations, staff interviews, and record review, the facility failed to ensure the resident food stored in the refrigerators in the nourishment rooms on 3 of 3 units was stored in a sanitary manner. This involved 3 of 3 units and had the potential to affect 96 of 98 residents residing in the facility. Findings include: 1.On 01/24/24 at 9:28 AM the refrigerator/freezer in the nourishment rooms on the 100 unit was inspected with the assistance of Corporate Dietary Manager 27 (CDM27). The refrigerator contained the following: Oikes yogurt with a use by date of 05/03/24. The container was not labeled with a name. An unlabeled and undated Styrofoam cup half full of a tan colored food substance. An open and half used 16-ounce bottle of Gatorade with no name or open date on it. A Dunkin donut bag with a breakfast sandwich in it with no name or date. A whole pizza in a pizza box with no name or date on it. A 4-ounce Sysco Imperial nutrition supplement with no date on it to indicate when it was thawed out. The instructions on the side of the carton stated to keep frozen and to use within 14 days of thawing. A plastic quart container of wonton soup with no label, name, or date on it. An undated and open 8-ounce container of mustard with the use by date worn off of it. On 01/24/24 at 9:34 AM, License Practical Nurse (LPN) 3 stated the refrigerator was for the	F 812	The 3 refrigerators located at each of the nursing units were cleaned thoroughly on January 29, 2024. Residents consuming items from each of the 3 refrigerators had the potential to be affected. The root cause of this deficient practice was that the facility failed to ensure the resident food stored in the refrigerators in the nourishment rooms on 3 of the 3 units was stored in a sanitary manner. Nursing staff will now be responsible to make sure that the food stored in the refrigerators in the nourishment rooms are stored in a sanitary manner. Nourishment room refrigerators will be checked weekly by the 11-7 shift and a form completed to verify completion. The completed forms will be reviewed by the QAPI Committee to make sure this problem does not recur. A Nourishment Room Refrigerator Audit tool will be completed daily by the DON and/or designee until the facility consistently reaches 100% success over 3 consecutive evaluations. Then, the audit tool will be completed three times a week until the facility reaches 100% success at 3 consecutive evaluations. Then, the audit tool will be completed once a week until the facility consistently reaches 100% success over 3 consecutive evaluations. Finally, the facility will measure one more time a month late. If the facility reaches 100%	

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F 812	Continued From page 17 residents' food; however, staff did put their food in it sometimes.ir 2. On 01/29/24 at 9:36 AM, Certified Nursing Assistant (CNA) 4 stated the third-floor nourishment refrigerator was for the residents, and the staff did not normally put their food in it. The third-floor nourishment room refrigerator contained the following items: A quart container of rice pudding with a resident name and room number. The container had a label on it stating it was packed in the deli on 01/23/24. It did not have a date to indicate when it was opened and placed in the refrigerator. CDM 27 stated it should have been discarded. A half-gallon size unlabeled/undated container of a red beverage. An unidentified container of food with no date or label. An opened and partially used quart container of Imperial brand thickened lemon water with no open date on it. It was three quarters full. CDM27 stated it should have been labeled with the open date and discarded within 7 days of it being opened. A partially used quart container of Chobari Greek Yogurt. The container was not labeled with a name or open date, and it was past the use by date of 1/14/24. A half-gallon container half full of mushy looking strawberries with no date on it. A quart size container of Cool Whip with no name or open date on it and no date to indicate when it was thawed out. The manufacturer's instructions on the side of the container stated to use within 2 weeks of thawing. The Cool Whip was past the use by date of 01/24/24. An undated/unlabeled quart size container of	F 812	success, the facility can condlude that it has successfully addressed the problem.	

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F 812	Continued From page 18 what appeared to be beans. An open 8-ounce carton of Hormel thick and easy honey consistency dairy beverage with no open date. An open 16-ounce bottle of strawberry preserves with no open date and a use by date of 12/12/23. A sandwich with some type of meat salad (tuna or chicken) in a bag with a date of 01/08/24. An undated/unlabeled quart container of what appeared to be rice and meat. An undated 20-ounce bottle of open Welches sparking pineapple juice. Tuna sandwich in a bag dated 01/20/24. A 16-ounce plastic container of what appeared to be lasagna. The container was dated 01/21/24. An unlabeled/undated 8-ounce plastic container of what appeared to be macaroni and cheese. An unlabeled/undated 8-ounce plastic container of what appeared to be collard greens. An unlabeled/undated bag with a baked potato and a half stick of margarine in it. Two breakfast pastries wrapped in aluminum foil. The food items were not labeled or dated. A plastic container of what appeared to be macaroni and cheese dated 12/23/23. The sign on the refrigerator recorded, "Remember to label and date all food and monitor all pass dates." 3. On 01/29/24 at 9:57 AM, the fourth-floor nourishment room refrigerator/freezer contained the following items: Three 4-ounce containers of berry "Magic Dessert Cup" with no thaw date. The label on the product stated to use within 5 days of thawing. Two 4-ounce containers of Sysco Imperial vanilla shake with no thaw date. The label on the	F 812		

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F 812	Continued From page 19 container recorded to use within 14 days of thawing. An undated/unlabeled piece of cake. A container of Great Value Greek vanilla yogurt with a resident's name on it and use by date of 11/1/23. An opened quart container of Sysco Imperial honey consistency thickened lemon flavored water with a date of 01/10/24 on it. The DM stated she did not know if the date was the date it was opened or the date it came into the facility. An opened half-quart container of cream cheese with no open date and an expiration date of 01/11/24. A package of hot dog buns with an expiration date of 12/12/23 and no resident's name. An open 8-ounce bottle of mayonnaise with an expiration date of 10/25/23. A hard peanut butter and jelly sandwich in a bag with a date of 01/06/24 on it. An undated plastic container with what appeared to be cranberry sauce. An undated/unlabeled plastic container of what appeared to be mashed potatoes and gravy. An undated/ unlabeled bag containing three hot dogs. The freezer contained: An unlabeled Styrofoam cup half full of what appeared to be ice cream. The cup had the date of 11/10/23 written on it; and A Lean Cuisine Salisbury steak and macaroni and cheese frozen dinner with a use by date of 08/13/23. The dinner was not labeled with a name. The refrigerator was soiled with a sticky substance on the shelves and bottom, and the freezer was soiled with a brown substance on the	F 812		

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F 812	Continued From page 20 top, bottom, and sides. CDM27 was present during each observation and verified all the items listed above and threw the items away as they were verified. CDM27 stated she did not know who was responsible for cleaning and checking the refrigerators. The facility 's policy titled, "Use and Storage of Food Brought in by Family or Visitors," revised 03/29/23, recorded the facility may refrigerate labeled and dated prepared items for the residents in the nourishment refrigerator on the unit. It was recorded that the prepared food must be consumed by the resident within 3 days and if not consumed within 3 days, the food would be thrown away by facility staff. The facility's "Food Storage: Cold Foods" policy, with a revised date of April 2018, recorded all foods would be labeled and dated and stored in a manner to prevent cross contamination.	F 812		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880		3/6/24

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F 880	Continued From page 21 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.	F 880		

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F 880	Continued From page 22 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record review, interviews, and facility policy review, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Specifically, the facility failed to ensure donning and doffing procedures, hand hygiene, and isolation precautions were followed according to facility processes to prevent the potential spread of infection to facility residents and staff. This had the potential to affect 98 of 98 residents who resided at the facility. Findings include: 1. An observation on 01/29/24 at 10:41 AM revealed R7's COVID-19 positive isolation room with an isolation cart and a doffing bin outside the room. The doffing bin label read, "Yellow isolation gowns . . . Please take to laundry at the end of each shift." The sign on the door read, "Stop, Contact and Droplet Precaution. You must perform hand hygiene before entering room and	F 880	Staff were not able to immediately correct the action for R7 and R64. However, CNA2 was educated immediately regarding proper hand hygiene and the use of gloves. All residents have the potential to be affected by these deficient practices. The root cause of these deficiencies is that the nursing staff failed to ensure donning and doffing, hand hygiene, and isolation precautions were followed according to facility processes to prevent the potential spread of infection to facility residents and staff. The SDC and/or designee will educate RNs, LPNs and CNAs on proper donning and doffing, hand hygiene and the use of gloves, and disposing of PPE trash. Education will also be done on the proper wearing of face masks and proper distancing when practical. An Infection Control audit will be	

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	085013	A. BUILDING _____ B. WING _____	C 02/01/2024

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F 880	Continued From page 23 Don proper PPE [personal protective equipment]. Doff PPE and perform hand hygiene before you exit. See nurse if you have any questions. Please keep this door closed." The Doffing sign posted above the isolation cart read, "Remove all PPE before exiting the patient room except a respirator, if worn." The PPE isolation signs showed symbols for gown, glove, mask, and face shield. There were no face shields or goggles in the isolation cart. An observation on 01/29/24 at 12:48 PM revealed lunch being served to R7 in a COVID-19 isolation room. Certified Nurse Aide (CNA) 20 looked in the isolation cart outside the resident room, and then went to the nurse station to retrieve a pair of goggles. CNA20 then returned to the isolation cart, donned a gown, gloves, goggles, and the N95 mask, entered the room with the lunch tray, and closed the door. CNA20 opened the door, took off her gloves, and hand sanitized. CNA20 then exited the resident room completely, shut the door, doffed, and rolled up the gown with bare hands, lifted the lid on the doffing bin in the hallway, and placed the gown inside. She then removed the goggles, wiped them down with an alcohol wipe, and placed them on the isolation cart. CNA20 then removed the N95 mask and placed it into a small white bag that was dropped onto the floor. She put on a new mask, went down the hallway to the other side of the unit, leaving the white bag on the floor. During an interview on 01/29/24 at 12:58 PM, Licensed Practical Nurse (LPN) 11 confirmed the small white bag was still on the floor outside R7's COVID-19 isolation room. She said she believed CNA20 had gone to find a trash can to put the bag in, since there was none by the resident	F 880	completed daily by the DON and/or designee until the facility consistently reaches 100% success over 3 consecutive evaluations. Then, the audit tool will be completed three times a week until the facility reaches 100% success at 3 consecutive evaluations. Then, the audit tool will be completed once a week until the facility consistently reaches 100% success over 3 consecutive evaluations. Finally, the facility will measure one more time a month later. If the facility reaches 100% success, the facility can conclude that it has successfully addressed the problem.	

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F 880	Continued From page 24 room. LPN11 donned gloves and picked up the untied bag and took it down the hallway to a trash room. An observation on 01/29/24 at 4:15 PM revealed R7 opened her door to leave the isolation room. Infection Preventionist (IP) spoke with the resident and stated she would go into the resident's room to speak with her. IP confirmed that the trash can was again placed outside the COVID-19 room, but that R7 often pushed it out of their room. She confirmed that doffing bins were regularly placed outside resident rooms and in common hallways during infection control processes. An observation on 01/31/24 at 1:15 PM revealed CNA6 entered R7's COVID-19 isolation room to bring her lunch. CNA6 donned PPE, entered the resident's room, and provided the resident their lunch. CNA6 stood in the doorway, doffed her gloves, and then wadded them up in her hand. CNA6 then doffed her gown with her bare hands and closed the door with the bare hand still holding the gloves. CNA6 tossed the gown into the doffing bin in the hallway, tossed the gloves into the trash can in the hallway, sanitized her hands, and then left. 2. An observation on 01/29/24 at 9:38 AM revealed a contact precaution sign on resident room door 312. A doffing bin was observed outside the resident room. An observation on 01/29/24 at 10:25 AM on the 4th floor unit revealed an enhanced barrier precaution sign on resident room 402, with a doffing isolation bin placed in the resident hallway outside the room. The bin label read, "Please	F 880		

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F 880	Continued From page 25 take to laundry at the end of each shift." Gown sleeves were hanging outside the lid of the bin. Observations on 01/30/24 at 1:50 PM revealed doffing isolation bins stationed outside resident rooms 212 and 312. Enhanced isolation precaution signs were placed on resident rooms 201, 212, 214, 219, and 232. Residents were regularly observed in the common hallways. 3. During an interview on 01/29/24 at 10:33 AM, LPN13 said that an N95 mask and full personal protective equipment (PPE) was required when entering a COVID-19 positive room, but a surgical mask was all that was required for the staff to wear in the rest of the facility. An observation on 01/29/24 at 12:25 PM revealed three CNAs sitting at tables in the resident communal area of the 4th floor doing paperwork. One CNA was observed with an N95 mask around their chin, one CNA had the mask off their nose and mouth and hung around their chin, and the third CNA had only one strap in place while wearing their N95 mask. Residents were observed in the 4th floor communal area. During an interview on 02/01/24 at 1:08 PM, IP stated that she provided infection control education with donning and doffing competencies during outbreaks or when educating staff. She said that during the infection control training, she would demonstrate donning and doffing, and then the staff member would demonstrate. She said she educated staff and agency both. She said the last outbreak in March 2023 was the last time she did donning and doffing competencies. IP said she also performed regular audits for compliance. She said that currently only R7 was COVID-19	F 880		

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F 880	Continued From page 26 positive and on contact and droplet precautions. IP said that all supplies were kept in front of the resident's door. She confirmed that one COVID-19 case was considered an outbreak, so staff were all required to wear a mask. She said that for staff going into a COVID-19 positive room, they should put on an N95 mask, gown, gloves, and goggles or a face shield before going into the room. IP said that to leave the room, staff should doff at the door. The staff should remove their gloves, and then they would remove the gown from the back and then roll it inside out. The staff would perform hand hygiene and then place the gown into a bag. They should then perform hand hygiene again. IP said they would then remove their mask, then perform hand hygiene, remove goggles, and wipe them with an infection control wipe. She said the gown should go into a bag and then the bag was to be thrown into the bin in the hallway for reusable gowns, the mask and gloves would be doffed and go into the trash can. IP confirmed that the doffing bins for PPE products used in isolation rooms were usually kept outside the resident rooms and in the facility hallways. She said that she had been aware that the staff should be doing a better job being compliant with mask use in the facility, that it was a constant battle, and they tried to educate in the moment. IP said they did need to tighten up their donning and doffing PPE process, bare hands, and disposing of trash. 4. Review of R64's "Admission Record," located in the electronic medical record (EMR) revealed R64 was admitted to the facility on 10/19/23 with diagnoses that included hypertension and depression. Review of R64's clinical record revealed that R64 had a diagnosis of Clostridioides difficile (C.diff, a highly contagious	F 880		

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F 880	Continued From page 27 inflammation of the colon) and was on contact precautions. During an observation on 01/29/24 at 12:24 PM, Transmission Based Precaution signage was noted on R64's door. The signage indicated R64 was on contact precautions. signage Certified Nursing Assistant (CNA) 2 entered R64's room with a lunch tray. R64 had two urinals on the side table. CNA2 put the lunch tray on the bed and proceeded to empty the urinals with no gloves on. CNA2 then put the lunch tray on the resident's bedside table and opened the packets on his tray. CNA2 exited the room with no hand hygiene, retrieved another lunch tray from the cart, and delivered it to another resident room. During an interview on 01/29/24 at 12:30 PM, CNA2 stated, "I used hand sanitizer when I emptied [R64]'s urinal. This is the last day [R64] is on precautions." When asked if gloves should have been worn, CNA2 stated, "No." During an interview on 01/29/24 at 12:45 PM, the Director of Nursing (DON) revealed, "If a resident is on C.diff precautions, then gloves should be worn when a urinal is emptied. That is the purpose of contact precautions of bodily fluids."	F 880		