STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085033	A. BUILDING _____ B. WING _____	C 09/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIKE CREEK NURSING & REHABILITATION CENTER	5651 LIMESTONE ROAD WILMINGTON, DE 19808

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 148 resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on interviews and reviews of clinical records, it was determined that for nine (R92, R108, R110, R113, R147, R411, R606, R167 and R508) out of 15 residents reviewed for ADLs (including toileting/showers), the facility failed to have sufficient staff to provide basic nursing care services in accordance with the residents' care plan and to meet each resident's needs. Findings include: Cross refer to F677, examples 2, 3, 4, 5, 6, 7, 8 and F697, examples 1 and 2 The facility failed to have sufficient staff to provide basic nursing care services to meet the following seven residents' needs:	F 725	F725- Sufficient Nursing Staff A. R92, R411, R167, R508, and R606 no longer reside in the facility. R110, R113, R147, R108 continue to reside at the facility. Identified residents have been assessed/interviewed for any unmet needs. Needs will be met and documented upon completion. B. All residents have the potential to be affected by the deficient practice. The NHA reviewed daily staffing sheets from August 1st to September 1st and the facility met or exceeded sufficient staffing requirements. DON/designee will run a 14 look back report to determine if any basic nursing care needs were not documented as completed. Identified care not	

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F 725	Continued From page 149 -R92 was cognitively intact and required assistance of two staff members as she was dependent for bathing/showers. R92 stated that she was not provided showers or had her hair washed. Clinical record revealed that R92 had no showers on 8/5/23, 8/12/23 and 8/19/23. -From 8/1/23 through 8/19/23, R108 was not provided toileting or incontinence care three times on day shift, six times on evening shift and six times on night shift. -R110 was cognitively intact and required extensive assistance of one staff member for bathing/showers. R110 stated that he had not been getting his showers twice a week from 8/1/23 through 8/18/23. Confirmed by record review and interview that R110 had only one shower on 8/14/23. -R147 was cognitively intact and required extensive assistance of one staff member for bathing/showers. R147 stated that she was not provided showers from 8/1/23 through 8/19/23. Confirmed by record review and interview. -R411 was cognitively intact and required staff assistance with toileting. R411 reported to the facility that her assigned CNA did not provide her any care and she laid in her stool for three hours on 8/19/23 day shift. -R113 was cognitively intact and required extensive assist of one staff member for toileting. R113 was not provided toileting assistance on 8/31/23 from 3:59 PM until the early AM hours of 9/1/23. -R606 had moderate cognitive impairment and	F 725	documented will be offered and documented upon completion. DON/designee will complete a pain assessment on each resident to ensure acceptable pain management is in place. C. A root cause analysis identified nursing staff did not complete resident basic nursing care needs. The RDCS/Staff Developer will educate the licensed nurses and CNA staff on the residents' plan of care and how to locate the Kardex/task, and orders/MAR/TAR. In addition, education will be presented to the licensed nurses and CNA staff on complete and accurate documentation. A daily labor meeting will be held. This meeting will consist of the staff scheduler, NHA and/or DON to ensure there are sufficient staff scheduled for the next 48 to 72 hours. Department heads will perform daily rounds (Angel Rounds) to include interviews with residents/family to ensure residents are receiving necessary services to maintain good grooming and necessary hygiene. UM/supervisor will run the POC compliance report prior to the end of the shift to verify completion of documentation. Communication huddles will occur daily by the unit manager/supervisor to communicate any changes in resident care. RDCS/Staff Developer will educate licensed nurses and CNA staff on pain management including assessments completed on admission, readmission, quarterly and with significant changes, the q shift pain assessment, the sign/symptoms of pain (both verbal and nonverbal), interventions for pain management and process for	

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F 725	Continued From page 150 required extensive assist of one staff member for toileting. R606 had no toileting assistance on 8/31/23 from 3:59 PM until the early AM hours of 9/1/23. -R167 pain was not managed resulting in the resident being sent to the emergency room for uncontrollable pain to the left hip causing harm to the resident. -R508 the facility staff failed to provide pain medication to a resident in pain in a timely manner. Additionally, R508 had a recommendation for adding another dose of morphine after being seen in a palliative care center and the facility failed to acknowledge or implement for a week. 9/8/23 at 12:30 PM - Findings were reviewed with E1 (NHA), E2 (RCD), and E3 (Interim DON). The facility failed to ensure that there were sufficient staff to meet the residents' basic nursing care needs for showering and toileting.	F 725	ineffective pain management. Cross Reference F697 Pain Management D. The DON/Designee will audit 5 residents to ensure ADL care is provided to residents and documented for compliance weekly x 4 weeks until 100%, then every 2 weeks x 1 month until 100%, then monthly x 4 months until 100%. DON/Designee will audit 20 residents q shift pain score to verify effective pain control weekly x 4 weeks until 100%, then every 2 weeks x 1 month until 100% and then monthly x 4 months until 100%. All audits will be submitted to the QAA committee monthly. The results of the audits will be reported X 4 months. The QAA committee will determine what, if any, additional intervention is needed at the end of the 4 months. E. Date of completion: 11/30/2023	
F 726 SS=E	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).	F 726		11/30/23

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F 726	Continued From page 151 §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, the facility failed to have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing services for two (R143 and R172) out of seventy-six (76) residents in the investigative sample to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment. Findings include: 1. Review of R143's clinical record revealed: 7/31/23 - R143 was admitted to the facility with multiple diagnoses including lung cancer and pneumonia.	F 726	F726- Competent Nursing Staff A. 1. R143 no longer resides at the facility 2. R172 no longer resides at the facility B. 1. All residents have the potential to be affected. DON/designee will review resident's bowel documentation for the past 3 days. If no bowel movement occurred, the bowel protocol will be initiated. 2. All residents who have an order for medication with parameters have the potential to be affected. DON/designee will review those residents' receiving medications with parameters to ensure parameters are correctly written and medication is administered as ordered. C. 1. Root cause analysis results identified failure of nurse to initiate bowel	

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F 726	Continued From page 152 8/1/23 - R143's care plan includes a nursing problem that the resident is at risk for constipation. The care plan intervention was to administer the constipation relieving medications when indicated. 8/28/23 - Review of the facility Documentation Survey Report revealed that R143 did not have a bowel movement from 8/1/23 at 11:19 PM until 8/7/23 at 11:22 PM. The review also revealed that R143 did not receive the constipation relieving medications that were ordered if he ever experienced constipation. 8/29/23 12:00 PM - During an interview, E56 (LPN) stated that the Electronic Medical Record (EMR) will alert a nurse when a resident has not had a bowel movement for three (3) days. E56 confirmed that R143 had not had a bowel movement documented from 8/1/22 at 11:19 PM until 8/7/23 at 11:22 PM and that constipation relieving medications had not been started for R143. E56 stated that a resident's constipation status is not part of a nursing shift to shift report. Review of the Facility Assessment reviewed 10/2022 revealed the following: - The Services Provided section page 3/5, revealed that the facility provides the management of medical conditions, including gastrointestinal conditions, of which constipation is included. - The Staff Competencies section p 4/14, revealed that Licensed Nurse Orientation topics include medication management, assessments and changes in condition. 2. Review of R172's clinical record revealed:	F 726	protocol per policy and failure to provide accurate shift to shift report regarding resident status. When starting their shift, the licensed nurse will review the PCC for pertinent information including but not limited to the clinical dashboard (which includes census data, BM list). If a resident is listed on the BM alert list, the 7 to 3 nurse will initiate the bowel protocol per provider direction. This will be documented in the EHR when initiated and effectiveness of bowel protocol. The 7 to 3 nurse will pass on during report if the bowel protocol was ineffective and the 3 to 11 nurse will initiate the next step and document it in the EHR. The 3 to 11 nurse will pass on during shift report if the bowel protocol was ineffective and the 11 to 7 nurse will initiate the 3rd step in the bowel protocol and document it in the EHR. If the resident did not have any effective results for the bowel protocol the licensed nurse will notify the provider for further direction. The UM/supervisors will pull a house wide BM alert list and follow up with licensed nurse to ensure the bowel protocol was started during their shift accordingly. The Staff Developer will educate licensed nurses on the constipation protocol and on how to locate clinical alerts within the EHR system, the steps within the bowel protocol and passing the progression of the bowel protocol along in shift to shift report. 1. Root cause analysis completed results identified that the nurse failed to transcribe orders correctly, medical provider failed to accurately review order prior to signing. An order recap report	

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F 726	Continued From page 153 5/10/22 - R172 was admitted to the facility with multiple diagnoses, including a primary diagnosis of anemia. 5/24/22 - A physician's order was written for Epoetin, a medication to treat R172's anemia, but the order was written to not give the medication if R172's Hemoglobin (Hgb) was less than 10 g/dl. A review of the prescribing information for Epoetin from the maker of the drug, Janssen Products, documents that the medication should be given when a Hgb level is less than 10 g/dL. 5/27/22 - R172 was sent to the hospital by ambulance. R172 was received as Trauma Code in the hospital emergency room with a critically low Hgb level. R172 needed to have emergency procedures to support and to maintain his life, including several blood transfusions, and further treatment in the hospital intensive care unit after R172's emergency care was provided. 8/16/23 - A review of R172's EMR documentation for Epoetin administration revealed that R172 did not receive an injection of Epoetin on 5/24/22. The reason that the nurse documented for not giving the medication was because R172's Hgb level was 9.8 g/dl. 8/29/23 10:15 AM - During an interview, E12 (LPN) stated that for the Epoetin order written to hold for Hgb less than 10, that she would have questioned/clarified why the medication would be held for a Hgb less than 10 g/dl. E12 stated that she knows that the medication should be given for a Hgb level below 10 g/dl.	F 726	which includes order summary and directions for administration will be ran and all new orders will be reviewed daily on 11-7 shift and at the clinical meeting to identify any inaccuracies, those identified will be brought to the provider's attention for further directions. A daily review of all consult order recommendations will be reviewed by the unit manager/supervisors to ensure accuracy and completion of order. The Medical Director will submit a memo to all providers educating them on reviewing each order for appropriate components (I.e; parameters, stop date, start date, route, dosage, frequency, etc) prior to signing the order. DON/designee will educate license nursing staff on transcribing orders, to ensure that the orders are read back to the provider to ensure accuracy and the parameters for medication(s). D. 1. DON/designee will audit 5 residents not having bowel movement in 3 or more days for bowel protocol initiation and shift to shift report weekly X 4 weeks until 100%, then every 2 weeks X months until 100%, then monthly X 4 months until 100%. All audits will be submitted to the QAA committee monthly. The results of the audits will be reported X 4 months. The QAA committee will determine what, if any, additional intervention is needed at the end of the 4 months. 2. DON/designee will review 5 residents with medication with parameters orders for accuracy to ensure that the medication is administered as ordered weekly X 4 weeks until 100%, then every 2 weeks X I month until 100%, then	

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F 726	Continued From page 154 8/29/23 10:25 AM - During an interview, E19 (LPN) stated that she would have questioned the physician or nurse practitioner about an Epoetin order that said to hold the med for less than 10 g/dl. The reason: Epoetin medication treats anemia and it should be given for Hgb below 10 g/dl. 9/8/23 at 11:30 AM - Findings were reviewed E1 (NHA), E2 (RCD) and E3 (DON).	F 726	monthly X 4 months. All audits will be submitted to the QAA committee monthly. The results of the audits will be reported X 4 months. The QAA committee will determine what, if any, additional intervention is needed at the end of the 4 months. E. Date of completion: 11/30/2023	
F 730 SS=E	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on interview and record review of facility documentation, it was determined that the facility failed to ensure that a performance review was completed at least every 12 months for five (E78, E79, E80, E81 and E82) out of six sampled employees. Findings include: Review of the latest performance appraisals for 6 randomly selected CNAs revealed the following performance review dates and performance review due dates: E78: 5/20/21 performance review for a 3/13/21 performance due date. E79: 1/20/21 performance review for a 11/26/20	F 730	F730- Nurse Aide Perform Review A. No residents were affected by the deficient practice. E78, E79, E80, E81, and E82 will receive their annual performance evaluation by 11/30. B. All residents have the potential to be affected by the deficient practice. A 100% audit of employee files for Nurse Aide Performance Review will be completed by the Human Resources Director/Designee. For those that are identified to have not been completed they will be completed by 11/30 with NHA being responsible to ensure completion. A Nurse aide performance review tracker will be developed to provide accurate tracking of	11/30/23

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F 730	Continued From page 155 performance due date. E80: 9/7/22 performance review for a 2/11/22 performance due date. E81: 1/7/22 performance review for a 11/18/2021 performance due date. E82: 9/24/22 performance review for a 4/24/22 performance due date. 9/8/23 at 11:30 AM - Findings were reviewed with E1 (NHA), E2 (RCD) and E3 (DON).	F 730	dates of hire and dates of evaluation completions. C. A root cause analysis identified the facility did not complete Nurse aide performance reviews every 12 months due to previous HRD resigning and new HRD starting without any tracking in place for evaluations. The RDCS/designee will provide education to the HR director and staff developer that the facility must complete a performance review of every nurse aide at least once every 12 months and must provide regular in-service education based on the outcome of the reviews. In addition, the HRD maintains a tracker listing nursing aid, hire date and due date for review. The tracker will be kept on the facility electronic file system so when changes in personnel occur, the management team can still see who needs a performance evaluation completed. D. The Human Resources Director/Administrator will audit 5 current staff weekly x 4 weeks until 100%, then every 2 weeks x 1 month until 100%, then monthly x 4 months until 100%. All audits will be submitted to the QAA committee monthly. The results of the audits will be reported X 4 months. The QAA committee will determine what, if any, additional intervention is needed at the end of the 4 months. E. Date of completion: 11/30/2023	
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4)	F 732		11/30/23

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F 732	Continued From page 156 §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by:	F 732		

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F 732	Continued From page 157 Based on interview and review of other pertinent documentation it was determined that the facility failed to maintain posted daily nurse staffing data for a minimum of 18 months. Findings include: 9/1/23 - The surveyor requested in an email to E1 (NHA) the posted daily nurse staffing data for the following dates: 11/4/22 [11 months] 1/16/23 [9 months] 2/26/23 [7 months]. During an interview on 9/6/23 at 1:33 PM E1 (NHA) confirmed the facility was unable to provide the postings for those dates, E1 stated that the facility "doesn't keep those, but we will". 9/8/23 at 11:30 AM - Findings were reviewed with E1 (NHA), E2 (RCD) and E3 (DON).	F 732	F732- Posted Nursing Staffing Information A. No residents were affected by the deficient practice. B. All residents have the potential to be affected by the deficient practice. The facility created a daily nurse staffing book where all daily nurse staffing postings will be filed to be maintained per regulation requirement. C. A root cause analysis identified the facility failed to keep daily nurse staffing postings for the required timeframe per regulation requirements. The RDCS/Staff developer will educate the scheduling coordinator and nursing supervisors on posting, in a prominent place, the daily nurse staffing information including facility name, current date, total numbers and actual numbers worked by direct care staff (RN, LPN, CNA) and the resident census. In addition, they will be informed that these postings are kept in the daily nurse staffing book for a minimum of 18 months. D. The Administrator/Designee will audit the posted daily nursing schedules and retention for compliance weekly x 4 weeks until 100%, then every 2 weeks x 4 month until 100%, then monthly x 2 months until 100%. All audits will be submitted to the QAA committee monthly. The results of the audits will be reported X 4 months. The QAA committee will determine what, if any, additional intervention is needed at the end of the 4 months. E. Date of completion: 11/30/2023	

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F 756	Continued From page 158	F 756		
F 756 SS=F	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take	F 756		11/30/23

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F 756	Continued From page 159 when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for seven (R25, R26, R59, R75, R125, R132, and R162) out of seven residents reviewed for unnecessary medication review the facility failed to provide evidence that the attending physician reviewed irregularities/recommendations documented on the monthly Medication Regimen Review (MRR). In addition, facility's Medication Regimen Review policy lacked the specific timeframe for the facility to respond to the pharmacy recommendations. Findings include: The facility policy on MRR last updated, August 2020, indicated "Resident specific irregularities and or clinically significant risk resulting from or associated with a medication are documented in their resident active record and reported to the DON, medical director and/or prescriber as appropriate...Recommendations are acted upon and documented by the facility staff and or the prescribe." 1. Review of R25's clinical record revealed: Review of the MRR's for R25 revealed that the pharmacist made recommendations to the attending physician on 3/20/23 and 5/14/23. Both MRR's lacked evidence of an attending or prescribing physicians response/review. The designated signature line was blank. During an interview on 8/28/23 at 2:46 PM E3 (DON) confirmed the finding and stated that the current reviewing physician is uncomfortable with	F 756	F756- Drug Regimen Review A. 1. R59, R125, and R162 no longer reside at the facility R25, R26, R75 continue to reside at the facility. The last Medication Regimen Review will be reviewed for each resident identified to determine if any recommendations exist and verify, they were followed. If recommendations were given and not followed, they will be reviewed by the in-house provider for further directions. B. The Director of Nursing/designee will audit Medication Regimen Review for current residents for the last 30 days. Any recommendations will be reviewed with the in-house provider for further recommendations C. The Director of Nursing/designee will educate Nurse Manager(s) (unit manager, ADON and house supervisors) on Medication Regiment Review and completion of recommendations after physician approval. The DON/designee will review the daily/monthly pharmacy reviews and assign them to residents□ provider. The assigned provider will review and submit recommendations within 14 days. The Administrator/designee will educate Residents□ provider to have the Medication Regiment Review with response within 14 days of receiving the recommendations. DON/UM/Supervisors will review physician directions are	

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F 756	Continued From page 160 historic recommendations and only conducting reviews of recommendations after June 2023. 2. Review of R162's clinical record revealed: 2/21/23 - Admission to the facility. 4/10/23 - MRR documented, R162 has been receiving therapy with Flonase nose spray in each nostril two times a day for allergies since 2/21/23. The pharmacist asked "can the Flonase therapy be discontinued at this time? If therapy is to continue can't the dose be decreased to the recommended maintenance dose of one spray in each nostril every day." 6/30/23 - MRR documented, the pharmacist recommendations discontinuing as needed use of lorazepam for R162, or reorder for 180 days, per the following federal guidelines. The MRR recommendations to the attending physician for both dates 4/10/23 and 6/30/23 the facility lacked evidence of an attending or prescribing physicians response and/or review. The designated signature line was blank. 9/7/23 4:44 PM - An email from E1 (NHA) confirmed this was all that they had available for R162's pharmacy review. 3. Cross Refer F758, Example #2 Review of R75's clinical record revealed: 7/6/23 - R75 was admitted to the facility. 8/24/23 9:00 AM - Review of R75's Consultant Pharmacist Report to the Physician dated	F 756	followed. The root cause of the deficient practice was lack of knowledge on the Medication Regimen Review process. D. The DON/designee will audit 5 residents Medication Regimen Review to determine if recommendations were made and follow up was completed weekly X 4 weeks until 100%, then every 2 weeks X 1 month until 100%, then monthly X 4 months until 100%. All audits will be submitted to the QAA committee monthly. The results of the audits will be reported X 4 months. The QAA committee will determine what, if any, additional intervention is needed at the end of the 4 months. E. Date of completion: 11/30/2023	

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F 756	Continued From page 161 7/29/23, revealed a recommendation to "reorder for a specific number of days PRN (when necessary) use of Trazodone, or discontinue per federal guidline". The facility failed to ensure that R75's July 2023 report with an irregularity identified by P2 (Pharmacist) was reported to the attending physician, the facility's medical director, and the director of nursing. 8/24/23 10:32 AM - In an interview, E2 (RCD) confirmed that the facility did not have the physician's response documentation in R75's clinical record. 4. Review of R132's clinical record revealed: 5/17/23 - R132 was admitted to the facility. 8/24/23 9:10 AM - Review of R132's clinical record revealed that the facility lacked evidence that a MRR was conducted for the months of May and June 2023. 8/24/23 10:35 AM - In an interview, E2 (RCD) confirmed that the facility did not have R132's pharmacy medication regimen review for the months of May and June 2023. 5. Review of R26's clinical record revealed: 6/29/23 - R26 was admitted to the facility with a diagnosis of right forefoot amputation, a right foot infection, bipolar disorder and vascular dementia. 6/30/23 - Review of R26's Consultant Pharmacist Recommendation to Nursing Staff revealed that R26's June 2023 report with a recommendation identified by P2 (Pharmacist) that documented...1. Please place a behavior/side	F 756		

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F 756	Continued From page 162 effect monitor form on the MAR (Medication Administration Record) for this resident to support the use of Mirtazapine and Risperidone... 2. It is required by OBRA (Omnibus Budget Reconciliation Act) guidelines that when on this medication the behavior and side effects must be monitored every shift... 3. None found on the chart. These recommendations had not been reported to the Medical Director and the Director of Nursing. 8/28/23 1:07 PM - Review of R26's MAR for 6/29/23, the month of July 2023 and the month of August 2023 revealed R26 had not been monitored for behaviors and or side effects for Mirtazapine and Risperidone. 8/28/23 1:19 PM - During an interview and observation E9 (LPN) revealed R26 did not have an order to monitor for behaviors and side effects as required for taking an antipsychotic and antidepression medication. 8/28/23 1:59 PM - An interview with E2 confirmed nursing did not review or sign P2's recommendation for R26." 6. Review of R59's clinical record revealed: 10/19/22 - R59 was admitted to the facility with a diagnosis of bipolar disorder, major depressive disorder, and anxiety. 3/19/23 - R59's Consultant Pharmacist Recommendation to P8 (MD) lacked evidence of P8's (MD) response and dated signature on the MMR (Medication Record Review) for R59. 4/11/23 - R59's Consultant Pharmacist	F 756		

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F 756	Continued From page 163 Recommendation to P8 lacked evidence of P8's response and dated signature on the MMR for R59. 5/17/23 - Review of R59's Consultant Pharmacist Recommendation to P8 (MD) documented... 1. Federal guidelines state antipsychotic drugs should have an attempt at a GDR (gradual dose reduction) twice per year for the first year in two different quarters with at least one month between attempts, then annually thereafter. Additionally, P6 (Consultant Pharmacist) documented... "This resident has been taking Latuda 40mg. daily since 10/18/22 for bipolar disorder, could you please indicate response below." Further review of P6's recommendation lacked evidence that P8 reviewed, responded, dated, and signed R59's MMR. 8/23/23 11:00 AM - Review of R59's clinical record lacked evidence that a GDR had been attempted for R59 for the antipsychotic medication, Latuda 40mg. daily. 8/28/23 1:53 PM - A brief interview with E2 confirmed the physician had not reviewed or signed P6's recommendation for a GDR. 7. R125's clinical record revealed: 6/13/23 - R125 was admitted to the facility with diagnoses including deep vein thrombosis (blood clot in the right lower extremity). 6/13/23 - R125's physicians' orders included lovenox 40 mg/0.4 ml (Enoxaparin Sodium) injection daily for deep vein thrombosis. 8/21/23 - There was no evidence in R125's	F 756		

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F 756	Continued From page 164 medical records that a pharmacist's review was conducted for the admission medications orders and for July 2023. 8/22/23 10:30 AM - The absence of the pharmacist's reviews were confirmed with E2 (Regional Clinical Director). 8. A policy and procedure titled, "Medication Regimen Review Policy # 11.1 dated 8/2020 documented ...D. "The prescriber is notified as needed." Further review of the policy had not indicated a detailed time frame for when the facility will respond to the Consultant Pharmacist recommendation. 8/28/23 1:53 PM - A brief interview with E2 (RCD) revealed "I provided a policy and procedure for the MRR (Medication Record Review)." E2 confirmed "I don't know what the time frame is for the physician to follow up on recommendations and irregularities from the Consultant Pharmacist." 9/8/23 at 12:30 PM - Findings were reviewed with E1 (Nursing Home Administrator), E2 (Regional Clinical Director), and E3 (Director of Nursing).	F 756		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant;	F 758		11/30/23

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F 758	Continued From page 165 (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.	F 758		

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F 758	Continued From page 166 This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for four (R25, R26, R59 and R75) out of seven residents reviewed for unnecessary medication review the facility failed to ensure residents were free from unnecessary psychotropic medication use. For R25 the facility failed to ensure an ordered psychotropic medication had the correct indication for use. For R75, the facility failed to ensure R75's medication regimen was free from unnecessary medications when he was prescribed and started using Trazodone Q 6 hours PRN for agitation. In addition, for R26, R59, and R75 the facility failed to initiate AIMS assessment for the use of anti-psychotic medication. Findings include: 1. Review of R25's clinical record revealed: 2/17/23 - A physicians order was written for R25 to have Buspar HCl Oral Tablet 15 MG by mouth three times a day for depression. According to https://www.drugs.com/buspar.html the indications for use of Buspar is anti-anxiety. 3/20/23- An MRR documented the following recommendation, "Resident is currently receiving Buspar with a diagnosis of depression. Per the manufacturer the only indication for the use of Buspar is anxiety. Can the diagnosis be updated at this time? Thank you". The MRR lacked evidence of physician response. During an interview on 8/29/23 at 10:04 AM E3 (DON) confirmed the finding and was unable to provide documentaion for use of Buspar outside of the indicated use.	F 758	F758- Free from Unnec Psychotropic Meds A. 1. R25 and R75 continue to reside at the facility. Providers will review residents□ medications to ensure correct indication for use by psychiatric services. 2. R26, R59, and R75 continue to reside at the facility, DON/designee will complete an AIMS test for identified residents. B. 1. All residents receiving psychotropic have the potential to be affected by this practice. DON/designee will audit all residents receiving psychotropic medications to ensure correct indication for use. Those identified as not having a correct indication for use will have appropriate diagnosis documented by psychiatric services. 2. All residents who have anti-psychotic medications ordered have the potential to be affected by this practice. DON/designee will audit all residents who have antipsychotic medication to ensure an AIMS test has been completed. Those identified as not having the AIMS will have one completed. C. 1. No policy changes are needed. Root cause analysis completed results identified knowledge deficit of providers ensure that the correct indication for use of psychotropic medications. Medical Director/designee will send memos to providers to outline correct indications for the use of psychotropic medications. New orders of psychotropic medications will be reviewed at clinical meetings to ensure that the correct indication for use is	

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F 758	Continued From page 167 2. Cross Refer F644. Review of R75's clinical record revealed: 7/6/23 - R75 was admitted to the facility with diagnoses including dementia. 7/6/23 - A physicians order for R75 to have Seroquel 25 mg (milligrams) tablet one time a day for bipolar disorder. 7/12/23 - Review of R75's Admission MDS assessment revealed that R75 did not have bipolar disorder listed as a diagnosis. 8/4/23 - A physicians order for R75 to have Seroquel 50 mg tablet at bedtime for bipolar disorder. 8/28/23 1:30 PM - Review of R75's updated PASARR (Preadmission Screening and Resident Review) with Notice Date 8/28/23 revealed that R75 was receiving Seroquel for anxiety. 8/28/23 1:35 PM - Review of R75's Admission MDS assessment dated 7/12/23 revealed that R75 did not have bipolar disorder listed as a diagnosis. 8/28/23 1:47 PM - In an interview, E25 (SW) stated that she completed tha PASARR application based on R75's information in the medical records and that R75 was receiving Seroquel for anxiety and not for bipolar disorder. E25 also stated that she will ask E17 (NP) for clarification. 8/12/23 12:30 PM - During an interview, E17 (NP) stated that resident (R75) was already on	F 758	indicated. If no appropriate diagnosis for the identified medication provider will be notified for further instructions. 2 No policy changes are needed. Root cause analysis completed results indicated that a knowledge deficit of the licensed nursing staff failed to complete AIMS test for residents who have antipsychotic medications. DON/designee will educate licensed nursing staff on the requirement of an AIMS test need to be completed for residents receiving antipsychotic medications. AIMS test will be scheduled for all newly prescribed antipsychotic medications. D. 1. DON/designee will audit 5 residents who receive psychotropic medications for correct indications for use weekly X 4 weeks until 100% then every 2 weeks X 1 month until 100% than monthly X 4 months until 100%. All audits will be submitted to the QAA committee monthly. The results of the audits will be reported X 4 months. The QAA committee will determine what, if any, additional intervention is needed at the end of the 4 months. 2. DON/designee will audit 5 residents who receive antipsychotic medications that AIMS test has been completed weekly X 4 weeks until 100%, every 2 weeks X 1 month until 100%, then monthly X 4 months until 100%. All audits will be submitted to the QAA committee monthly. The results of the audits will be reported X 4 months. The QAA committee will determine what, if any, additional intervention is needed at	

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F 758	Continued From page 168 Seroquel while he was at the hospital and came with the orders on admission. E17 further confirmed that resident did not have a bipolar disorder and that he was getting Seroquel for his anxiety. E17 stated, "...The nursing staff who transcribed the order electronically must have put the bipolar disorder diagnosis by mistake." The facility failed to ensure an ordered psychotropic medication, Seroquel, had the correct indication for use. 3. Review of R26's clinical record revealed: 6/29/23 - R26 was admitted to the facility with a diagnoses of a right forefoot amputation, a right foot infection, bipolar disorder, and vascular dementia. 8/28/23 1:30 PM - Review of R26's clinical record lacked evidence that a baseline AIMS (Abnormal Involuntary Movement Scale) had been completed for the use Risperidone 0.5 mg. (milligrams), an anti-psychotic medication, at bedtime for the diagnosis of bipolar disorder. 8/28/23 1:53 PM - E2 (RCD) confirmed that, "An initial baseline AIMS assessment had not been done for R26". 4. Review of R59's clinical record revealed: 10/19/22 - R59 was admitted to the facility with a diagnoses of bipolar disorder, major depressive disorder, and anxiety. 8/27/23 8:27 AM- Review of R59's clinical record lacked evidence that a baseline AIMS assessment had been completed for the use of	F 758	the end of the 4 months. E. Date of completion: 11/30/2023	

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F 758	Continued From page 169 Latuda 40 mg daily, an anti-psychotic medication. 8/28/23 9:15 AM - E2 (RCD) confirmed that, an initial admission AIMS assessment had not been done for R59. 9/8/23 at 11:30 AM - Findings were reviewed with E1 (NHA), E2 (RCD) and E3 (DON).	F 758		
F 760 SS=D	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. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, it was determined that for one (R160) out of three reviewed for hospitalization the facility failed to ensure that R160 was free of significant medication errors. For R160 the facility failed to administer a seizure medication for three days and anti-coagulant therapy. Findings include: 1. Cross refer F41 and F655 The following was reviewed in R160's clinical record: 5/21/23 - R160 was diagnosed with an occlusive deep vein thrombosis (DVT) in her right arm. Per the U.S Food and Drug Administration, enoxaparin (Lovenox) is indicated for an acute DVT without pulmonary embolism (PE), the standard dosage and treatment duration in the inpatient setting is 1 mg (milligram) per kg (kilogram) subcutaneously (under the skin) every	F 760	F760- Free of Significant Med Errors A. R160 no longer resides at the facility. No corrective action required B. All residents have the potential to be affected by this practice. DON/Designee completed a 100% audit of all residents who are ordered seizure medication and/or an anti-coagulant medication to verify medication is being administered as order. If medication is unavailable, it will be obtained. Those residents identified with missed medication will be communicated to the provider for follow-up. C. It was determined that the root cause was the facility staff failing to follow policy and procedure on medication ordering and following up on medications being unavailable. A root cause was also determined to be identified due to untimely delivery of pharmacy medications. The DON/Designee will	11/30/23

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PIKE CREEK NURSING & REHABILITATION CENTER	5651 LIMESTONE ROAD WILMINGTON, DE 19808

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 170 12 hours. (October 2015) Per the American Society of Hematology 2020 Guidelines for Management of Venous Thromboembolism: treatment of deep vein thrombosis and pulmonary embolism, the initial management of a DVT spans the first 5 to 21 days following the diagnosis of a new DVT. Primary treatment continues anticoagulant therapy for 3 to 6 months total and represents the minimal duration of treatment for the DVT. (Blood Advances (2020)4 (19) 4693-4738) 6/16/23 10:15 PM - R160's weight was 126.4 pounds. 6/16/23 10:54 PM - R160 was admitted to the facility with diagnoses that included: stroke, vascular dementia and epilepsy (seizure disorder). Of note, June 16, 2023, was a Friday. 6/16/23 2:44 PM- R160 's medical record documented a phone order by E28 (MD) stating, "Admit to skilled level of care. I have reviewed and agree with the plan of care, orders and diagnoses. I certify that this resident (R160) requires SNF (Skilled nursing facility) level of care for 30 days". 6/16/23 10: 57 PM- A phone order from E28 (MD) stating, "Lacosamide (Vimpat- an anti-seizure medication) oral tablet 100 mg- Give 2 tablets by mouth two times a day for seizures". This medication was scheduled to be administered at 8 AM and 4 PM per R160's Medication Administration Record (MAR) for June 2023. 6/16/23 10:57 PM- A phone order from E28 (MD)	F 760	in-service licensed nurses on medication ordering and process if medications are not available, to include location of over-the-counter medications, the use of back up medications, use of back-up pharmacy, and provider notification of missed medication. The DON/Designee will monitor a daily pharmacy delivery report to ensure compliance. D. The DON/Designee will audit all residents on seizure medication and/or anti-coagulant medication to verify medication is being administered as ordered weekly x 4 weeks until 100%, then every 2 weeks x 1 month until 100% and then monthly x 4 until 100%. All audits will be submitted to the QAA committee monthly. The results of the audits will be reported X 4 months. The QAA committee will determine what, if any, additional intervention is needed at the end of the 4 months. E. Date of completion: 11/30/2023	

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F 760	Continued From page 171 stating, "Valproic Acid Oral Solution (an anti-seizure medication) 250 mg/ 5 ml- Give 10 ml via PEG-Tube three times a day for anticonvulsant" (to prevent seizures). 6/17/23 8 AM to 6/19/23 4 PM- R160's MAR has documented by four different nurses in the lacosamide sign off box "9". The MAR key reveal that "9" corresponds with 9 = "Other/See Progress Note Effective". 6/17/23 9:07 PM - E27 (Agency LPN) documented in Point Click Care (PCC) Progress Note, "lacosamide 100 mg- give two tablets by mouth two times a day for seizure- pending pharm (sic) delivery". 6/18/23 12:39 PM- E61 (LPN) documented in PCC Progress Note, "lacosamide 100 mg- give two tablets by mouth two times a day for seizure - medication ordered with pharmacy; pharmacy state script needed. NP (nurse practitioner) NOTIFIED." 6/18/23 8:06 PM - E61 (LPN) documented in PCC Progress Note, " ...Resident lacosamide ordered with pharmacy, pharmacy contacted stated awaiting script. NP on-call notified, NP on-call to contact pharmacy with script. NP & RP (representative person) notified." 6/18/23 11:05 PM - E61 (LPN) documented in PCC Progress Note, "lacosamide 100 mg- give two tablets by mouth two times a day for seizure- medication ordered with pharmacy, pharmacy state no script faxed over for resident. NP on-call notified." 6/19/23 12:48 PM - E28 (MD) documented in	F 760		

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F 760	Continued From page 172 PCC R160's Admission History & Physical, " ...Diagnoses, Assessment & Plan: ...Seizure Disorder- Patient without seizure activity at this time and continue with valproic acid 250 mg per 5 mls -give 10 mls via the PEG tube 3 times a day and Vimpat (locasmide) 100 mg 2 tabs 2 times a day for seizures and I did fax over her prescription for the Vimpat ...". 6/19/23 2:47 PM - E62 (RN) documented in PCC Progress note, " lacosamide oral tablet 100 mg- give 2 tablets by mouth two times a day for seizure- medication not available, this writer contacted pharmacy. Requires new script. MD made aware by nursing supervisor." 6/19/23 5:59 PM - E66 (LPN) documented in PCC Progress note, "lacosamide 100 mg- give two tablets by mouth two times a day for seizure- unavailable". Review of the MAR documented R160 missed six scheduled doses (6/17/23 8 AM & 4 PM, 6/18/23 8 AM & 4 PM, 6/19/23 8 AM & 4 PM) of lacosmide (Vimpat) due to the delay in having the prescription/C2 form faxed to the dispensing pharmacy. 6/19/23 2:56 PM - A verbal order from E28 (MD) was entered in R160's medical record under Pharmacy stating, "Enoxaparin Sodium (Lovenox- a blood thinning medication) Injection Solution Prefilled Syringe 60 mg (milligrams)/ 0.6 ml (milliliters)- Inject 60 mg subcutaneously (under the skin) every 12 hours for DVT (deep vein thrombosis) prophylaxis". This medication was scheduled to be administered at 9AM and 9 PM per R160's MAR.	F 760		

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F 760	Continued From page 173 6/19/23 9:00 PM - R160's MAR documented the first dose of enoxaparin (Lovenox) given by nursing staff. R160 missed her anti-coagulant medication administration on 6/17/23, 6/18/23 (2 doses) and 6/19/23 (AM dose) for a total of five doses missed. 9/8/23 at 11:30 AM - Findings were with E1 (NHA), E2 (RCD) and E3 (DON).	F 760		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can	F 761		11/30/23

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F 761	Continued From page 174 be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that for two (2) out of three medication rooms the facility failed to ensure that medications that required refrigeration were stored under the proper temperatures. Additionally, in one (1) out of three medication rooms the facility failed to securely store a Schedule II controlled drug in a locked and permanently attached compartment. Findings include: 8/16/23 12:30-1:30 PM - Observations of the Fenwick and Bethany Unit medication rooms and refrigerators revealed: - The Fenwick Unit refrigerator temperature control log was missing the daily recorded temperatures for the August 1, 2, 3, 13 and 14, 2023. Drugs that required refrigeration were present in the refrigerator. -The Fenwick Unit medication room had an unlocked refrigerator that contained a 15 ml bottle of Morphine Sulfate 20 mg/ml, which was in an unlocked container that was not permanently attached to the refrigerator. 8/16/23 1:30 PM - During an interview, E4 (RN UM) confirmed the above. 8/16/23 - A Review of the Drug Enforcement Agency Drug Fact Sheet revealed that Morphine is a Schedule II narcotic under the Controlled Substances Act. 9/8/23 at 11:30 AM - Findings were reviewed with	F 761	F761- Label/Store Drugs and Biologicals A. There were no residents affected by this deficient practice. B. All residents have the potential to be affected by this deficient practice. All medication refrigerators' temperatures were checked and verified to be within the allowable range. All the medication refrigerators were assessed to ensure controlled boxes were permanently attached and placement of lock on outside of refrigerator was installed. C. It was determined that the root cause was the facility staff failed to assess and document daily temperature monitoring for medication refrigerators and the facility failed to ensure medication refrigerator had appropriate securement for controlled drugs. The 7 to 3 nurse will be responsible for ensuring the daily temperature log is completed. The DON/Designee will provide in-service to licensed nurses on medication storage policy including monitoring medication refrigerators temperatures daily and double locking of narcotic medication in medication refrigerators. D. The DON/Designee will audit all medication room refrigerators daily for daily temperature checks and double locking of controlled medications x 4 weeks until 100%, then every 2 weeks x 1 month until 100%, and then monthly x 4 until 100%. All audits will be submitted to the QAA committee monthly. The results of the audits will be reported X 4 months.	

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F 761	Continued From page 175 E1 (NHA), E2 (RCD) and E3 (DON).	F 761	The QAA committee will determine what, if any, additional intervention is needed at the end of the 4 months. E. Date of completion: 11/30/2023	
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. (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 record review, it was determined that for one (R182) out of ten residents reviewed for change of condition, the facility failed to obtain laboratory services. Findings include: Cross refer to F684, example 4 Review of R182's clinical record revealed: 7/12/23 at 12:10 PM - A physician's order, entered by E17 (NP), stated, "BMP every night shift every Sunday." R182's clinical record lacked evidence of a BMP	F 773	F773- Lab Services A. R182 no longer resides at the facility. No corrective action required. B. All residents have the potential to be affected by this deficient practice. DON/Designee will audit past 30 days of lab orders for current residents to ensure lab was obtained and results are within the EHR. Any missed labs identified will be reported to the provider for further direction. C. It was determined that the root cause was the facility staff failed to follow the laboratory/diagnostic testing policy due to lack of education. Once an order has	11/30/23

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F 773	Continued From page 176 lab. 8/28/23 at 10:57 AM - During an interview, E3 (Interim DON) confirmed that the ordered lab was never done. 9/8/23 at 12:30 PM - Finding was reviewed with E1 (NHA), E2 (RCD) and E3 (Interim DON).	F 773	been received for a laboratory test, the nurse will put the order in the laboratory logbook under the day it is to be drawn. The 11 to 7 nurse will run the order recap during their shift to verify any laboratory orders that were written and verify it was added to the laboratory tracking logbook. If the lab was not added, the 11 to 7 nurse will add it. The um and/or 7 to 3 shift nurse will check the lab tracking logbook to verify the lab was drawn and signed off by the lab technician. If any lab was not signed off by the lab technician, the nurse will notify the provider for further direction. The UM and/or day shift nurse will verify the results from the morning lab draw has been received prior to the end of their shift. If the result has not been received, the information will be passed on in shift report for the nursing supervisor and/or 3 to 11 nurse to obtain results. The RDCS/Staff developer will provide education to licensed nurses on the laboratory testing policy to include tracking laboratory draws on the lab tracking logbook and the resulting of that laboratory draw. RDCS/staff developer will educate the evening supervisor on verifying the laboratory draws obtained in the morning have been resulted and accounted for. RDCS/Staff developer will educate the night supervisor on verifying any order for laboratory draws is listed in the lab logbook prior to the morning draw. D. The DON/Designee will audit laboratory orders and laboratory logbooks to ensure draw completed weekly x 4 until 100% compliance, then every 2 weeks x 1 month until 100%	

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F 773	Continued From page 177	F 773	compliance and then monthly x 4 until 100% compliance is achieved. All audits will be submitted to the QAA committee monthly. The results of the audits will be reported X 4 months. The QAA committee will determine what, if any, additional intervention is needed at the end of the 4 months. E. Date of completion: 11/30/2023	
F 803 SS=C	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be	F 803		11/30/23

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F 803	Continued From page 178 construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined that the facility failed to ensure residents were served meals that followed the menu displayed. The first floor Fenwick unit [week 4], second floor unit [week 1 and 4] and front lobby [week 3] displayed menu's that didn't reflect the current menu selection of week 2. Additionally for R104 the facility failed to serve the meal listed on the menu. Findings include: During an interview on 8/17/23 at 4:18 PM R104 stated, "They do not they give us a menu they don't bring you what you choose." 8/29/23 11:54 AM - Observation of posted menu on the second floor displayed the current menu as "week 1 Tuesday Beef Stew alt (alternate) breaded fish". 8/29/23 11:57 AM - R104 was served chicken tenders and stated, "They give you a menu but they serve you whatever they want". During an interview on 8/29/23 at 2:22 PM, E50 (DA) stated, "Patients hand in a menu we put what they choose. We are on week 2 which does reflect tenders served today". E50 was shown the menu display at R140's nurses station for week one with beef stew, E50 then stated "We will correct that". 8/30/23 at 10:47 AM - 10:51 AM The following observations were made: Fenwick unit incorrectly displaying week 4 menu Front lobby incorrectly showing week 3 menu.	F 803	F803- Menus Meet Resident Needs A. Upon discovery, the Food Service Director replaced the menu displayed menus on the Fenwick unit, second floor unit, Bethany unit, and front lobby to the current menu selection for week 2. All other areas where the menu is posted were checked to ensure week 2 was posted. R104 still resides in the facility. R104 receives a weekly menu, and a dietary aide provides assistance with completion for accuracy. B. All residents have the potential to be affected by this deficient practice. The Food Service Director will complete an audit of all displayed menus to ensure the accurate menu is posted for the week, if weekly menu not posted the food service director will replace with accurate menu C. A root cause analysis identified the facility failed to ensure the weekly menus posted reflected the correct scheduled week. The Administrator will educate the Food Service Director on ensuring accurate menus are displayed throughout the facility. The Food Service Director will educate all dietary staff. D. Administrator/Dietician will audit all menu postings for compliance weekly x 4 weeks until 100%, then every 2 weeks x 1 month until 100%, then monthly x 4 months until 100%. All audits will be submitted to the QAA committee monthly. The results of the audits will be reported X 4 months. The QAA committee will	

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F 803	Continued From page 179 First floor Bethany unit no menu display. During an interview on 8/30/23 at 10:54 AM, E29 (DDS) confirmed the menu's displayed did not reflect the current menu offered to residents, E29 stated she would change the menus immediately. 9/8/23 at 11:30 AM - Findings were reviewed with E1 (NHA), E2 (RCD) and E3 (DON).	F 803	determine what, if any, additional intervention is needed at the end of the 4 months. E. Date of completion: 11/30/2023	
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation of and two out of two test tray results, it was determined that the facility failed to provide food at a palatable taste. Findings include: 1. A test tray was conducted at both hallways of the facility on 8/21/23 on 12:50 PM at Bethany Wing and Medbridge Unit 1:30PM. - Ruben: 140F - Vegetable mix: 143F Test trays tasted by three surveyors between 12:50 PM through 1:30 PM. Consensus was unanimous that the food was bland, watery, and	F 804	F804- Nutritive Value/Appear/Palatable A. No residents were affected by the deficient practice. B. All residents have the potential to be affected by the deficient practice. The Regional Dietary Manager conducted a meal test tray to determine areas of improvement. C. A root cause analysis identified the facility did not conduct a food test tray prior to serving the meal to ensure the meal served has a palatable taste. The Administrator will educate the Food Service Director on ensuring a test tray is sampled daily for palatability prior to	11/30/23

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F 804	Continued From page 180 not very good. 9/8/23 at 11:30 AM - Findings were reviewed with E1 (NHA), E2 (RCD) and E3 (DON).	F 804	serving to the residents. The Regional Dietary Manager has educated the Food Service Director on ensuring meals are appetizing to residents, palatable, and served at appropriate temperatures for residents to enjoy. Resident meal satisfaction surveys will be discussed in the monthly resident council meeting to determine overall meal satisfaction. Department heads will perform daily rounds (Angel Rounds) to include interviews with residents/family to include meal satisfaction. D. A member of the administrative staff will sample one test tray daily prior to meal service to ensure the meal is palatable with feedback provided weekly x 4 weeks until 100%, then every 2 weeks x 1 month until 100%, then monthly x 2 months until 100%. 5 residents will be interviewed weekly x 4 weeks until 100%, then every 2 weeks x 1 month until 100%, then monthly x 2 months until 100% with acceptable palatability. All audits conducted by the Administrator/Designee will be submitted to the QAA committee monthly. The results of the audits will be reported X 3 months. The QAA committee will determine what, if any, additional intervention is needed at the end of the 3 months. E. Date of completion: 11/30/2023	
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 -	F 812		11/30/23

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	085033	A. BUILDING _____ B. WING _____	C 09/25/2023

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PIKE CREEK NURSING & REHABILITATION CENTER	5651 LIMESTONE ROAD WILMINGTON, DE 19808

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F 812	Continued From page 181 §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to provide and store food in accordance with professional standards for food service safety. Findings include: During the initial kitchen tour on 8/17/23 at approximately 8:30 AM, the hand sink by the dish washing area was found to have excessive dirt and grease in the wash basin. Furthermore, the ceiling at the beverage area was observed to be caving down exposing the contents above the ceiling tiles. Finding was reviewed and confirmed by E29 (food service director) on 8/17/23 at approximately 11:30 AM.	F 812	F812- Food Procurement A. No residents were affected by the deficient practice. The hand sink was immediately cleaned and sanitized by the Food Service Director. The ceiling at the beverage area was repaired by maintenance. B. All residents have the potential to be affected by the deficient practice. An audit of all kitchen sinks and ceiling tiles was completed and the findings were corrected. A daily cleaning schedule was developed and implemented by the Food Service Director. C. A root cause analysis identified the sink was not cleaned properly after use by staff. The facility failed to implement the facility preventative maintenance program effectively to report ceiling disrepair. Hand sinks in the kitchen will be used for	

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F 812	Continued From page 182	F 812	washing hands only. They will be cleaned at least daily per the cleaning schedule. Daily inspections of the kitchen will be completed, and any repairs needed will be communicated to the maintenance department for completion. The Administrator will educate the Food Service Director and dietary staff on kitchen cleanliness, the daily kitchen cleaning schedule and how to report needs to the maintenance department for repair. D. Administrator/designee will audit cleanliness and kitchen environment weekly x 4 weeks until 100%, then every 2 weeks x 1 month until 100%, then monthly x 2 months until 100%. All audits conducted will be submitted to the QAA committee monthly. The results of the audits will be reported X 4 months. All audits will be submitted to the QAA committee monthly. The results of the audits will be reported X 4 months. The QAA committee will determine what, if any, additional intervention is needed at the end of the 4 months. E. Date of completion: 11/30/2023	
F 835 SS=F	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced	F 835		11/30/23

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F 835	Continued From page 183 by: Based on observations, interviews and survey investigative findings, it was determined that the facility failed to be administered in a manner that enabled it to use its resources effectively and efficiently during a COVID-19 outbreak where the facility failed to implement their infection control program, despite having a COVID-19 policy and procedure and access to the current guidance from the Centers of Disease Control and Prevention (CDC). Findings include: Cross refer to F880, example 1 On 6/5/23, the facility management signed a Health Care Staffing Agreement for a interim RN Director of Nursing (E3) with a start date of 7/11/23 through 8/11/23 (finish date). The signed agreement stated that "...Finish dates may be extended by agreement between (name of staffing company) and Client (facility)...". Also specified under "Additional Terms: ... *It is understood that the consultant will function in a management level role and will not be assigned routine, direct patient care or staff nurse duties, such as delivering medications or performing treatments." On 8/16/23 at 11:00 AM, the Survey Team entered the facility and was informed that the facility had one positive COVID-19 resident. During the Entrance Conference with E1 (NHA), the Surveyor was informed that E3 (Interim DON) was the facility's Infection Control Preventionist (ICP), but she was currently on vacation all week and out of the facility. E3 would return on Monday, 8/21/23. The facility provided the Surveyor with a copy of E3's CDC web-based certification for Nursing Home Infection	F 835	F835- Administration A. Regional nurse took over infection control preventionist role and implemented CDC COVID-19 guidelines. B. All residents have the potential to be affected by the deficient practice. The facility immediately initiated broad based testing of COVID-19 for residents and staff. The NHA notified the Department of Public Health of the COVID-19 outbreak. The RDCS educated the NHA, DON and staff developer/infection preventionist on the COVID-19 infection control program that included: initiation of contact tracing and identification of close contact/exposures, conducting serial testing, notifying the DPH of the COVID-19 outbreak, and educating staff working in the facility of the COVID-19 outbreak and using source control. The facility filled the staff development position who has obtained her Infection Control Preventionist certification and will serve as the facility ICP, with the DON as backup. The facility is actively recruiting (utilizing the corporate recruiter, various job sites and social networking) for key leadership positions with a variety of sign on bonuses offered. The facility has a permanent Director of Nursing who will be starting mid December 2023 and one permanent unit manager has already started. In addition, the facility has brought in 6 corporate nurses who will provide day to day oversight of clinical services including overseeing 1st floor nursing units, overseeing 2nd floor nursing units, overseeing MDS department, overseeing	

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F 835	Continued From page 184 Preventionist Training Course dated 4/13/23 later that afternoon. The Surveyor asked who was the Assistant Director of Nursing (ADON) and Staff Educator and was informed that the facility did not have an ADON or a Staff Educator. From 8/16/23 through 8/21/23, there was no ICP in the facility. 8/22/23 at 1:23 PM - In response to additional residents testing positive for COVID-19 during the survey, a combined interview with E3 (Interim DON/ICP) and E4 (UM/RN) revealed that the facility did not conduct contact tracing and focused/broad-based COVID-19 testing according to CDC guidance and the facility's policy and procedure. At 4:40 PM, an Immediate Jeopardy was called for F880 - the failure to implement the facility's infection control program for COVID-19. 8/29/23 at 12:38 PM - During an interview about key facility staff positions, E1 (NHA) confirmed the following: - the last Assistant Director of Nursing (ADON) worked from 5/30/23 through 6/20/23; and - the last Staff Educator worked from 2/2/23 through 3/20/23. The Surveyor was also informed that E4 (UM/RN) was in the process of obtaining her ICP certification at the time. The facility failed to be administered in a manner that enabled it to use its resources effectively and efficiently by ensuring key staff positions and infection control responsibilities were covered during E3's absence from the facility.	F 835	infection control and staff educating. C. A root cause analysis identified the facility□s infection control policies and procedures were not utilized during a Covid-19 outbreak that occurred in the facility, due to knowledge deficit and the facility failed to cover ICP responsibilities during the ICP absence. The staff developer is infection control certified and will oversee the infection control program. In their absence the director of nursing will perform that role and function. If both are out of the facility, then the corporate nurse will oversee the infection control program until their return. The RDCS/designee will educate the Administrator on Covid-19 policies/procedures and the requirements for an infection preventionist. D. RDCS/designee will audit the facility to ensure its use of resources is managed effectively by ensuring key staff positions and infection control responsibilities are covered weekly x 4 weeks until 100%, then every 2 weeks x 1 month until 100%, then monthly x 4 months until 100%. All audits will be submitted to the QAA committee monthly. The results of the audits will be reported X 4 months. The QAA committee will determine what, if any, additional intervention is needed at the end of the 4 months. E. Date of completion: 11/30/2023	
F 842 SS=D	Resident Records - Identifiable Information	F 842		11/30/23

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F 842	Continued From page 185 CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert	F 842		

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F 842	Continued From page 186 a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that for one (R182) out of ten residents reviewed for a change of condition, the facility failed to ensure that her medical record was complete. Findings include: Cross refer to F684, examples 4 and 5 R182's medical record revealed:	F 842	F842- Resident Records A. R182 no longer resides at the facility. No corrective action required. B. All residents have the potential to be affected by this deficient practice. DON/Designee will audit the past 24 hours of CNA documentation to determine if any missing documentation exists. Any missing documentation will be followed up on with appropriate staff members and	

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F 842	Continued From page 187 Despite only being in the facility from 7/3/23 to 7/20/23, R182's July 2023 CNA Documentation Survey Report lacked evidence of documentation for: -18 out of 50 meal intakes; -9 out of 17 bedtime snacks; -21 out of 52 shifts of her Kardex (care plan) reviewed by CNAs; -22 out of 51 shifts of bowel/bladder elimination; -20 out of 52 shifts of transferring Activity of Daily Living (ADL); -20 out of 52 shifts of toilet use ADL; -2 out of 5 scheduled shower opportunities; -13 out of 34 shifts of personal hygiene (included combing hair, brushing teeth, washing face and hands) ADL; -13 out of 34 shifts of eating (self performance/support provided) ADL; -13 out of 34 shifts of dressing (self performance/support provided) ADL; and -20 out of 52 shifts of bed mobility (self performance/support provided) ADL. 8/31/23 at 4:30 PM - During an interview, findings were reviewed and discussed with E1 (NHA) and E3 (Interim DON). 9/8/23 at 12:30 PM - Findings were reviewed with E1 (NHA), E2 (RCD) and E3 (Interim DON). The facility failed to ensure that R182's medical record was complete.	F 842	corrected if applicable. C. It was determined that the root cause was the facility staff failed to document care provided in the medical record and develop a system for monitoring. The DON/SDC will in-service CNA staff on documentation requirements and documentation is to occur on the kiosk in the hallway in real time. DON/SDC will educate nurse management team on monitoring the documentation twice during the shift to verify completion and addressing it in real time. In the off hours, PCC will also be monitored by designated management staff offsite and will be communicated to the center when issues arise. D. The DON/Designee will audit CNA documentation weekly x 4 weeks until 100% compliance, then every 2 weeks x 1 month until 100% compliance and then monthly x 4 months until 100% compliance is achieved. All audits will be submitted to the QAA committee monthly. The results of the audits will be reported X 4 months. All audits will be submitted to the QAA committee monthly. The results of the audits will be reported X 4 months. The QAA committee will determine what, if any, additional intervention is needed at the end of the 4 months E Date of completion: 11/30/2023	
F 843 SS=E	Transfer Agreement CFR(s): 483.70(j)(1)(2) §483.70(j) Transfer agreement. §483.70(j)(1) In accordance with section 1861(l)	F 843		11/30/23

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F 843	Continued From page 188 of the Act, the facility (other than a nursing facility which is located in a State on an Indian reservation) must have in effect a written transfer agreement with one or more hospitals approved for participation under the Medicare and Medicaid programs that reasonably assures that- (i) Residents will be transferred from the facility to the hospital, and ensured of timely admission to the hospital when transfer is medically appropriate as determined by the attending physician or, in an emergency situation, by another practitioner in accordance with facility policy and consistent with state law; and (ii) Medical and other information needed for care and treatment of residents and, when the transferring facility deems it appropriate, for determining whether such residents can receive appropriate services or receive services in a less restrictive setting than either the facility or the hospital, or reintegrated into the community will be exchanged between the providers, including but not limited to the information required under §483.15(c)(2)(iii). §483.70(j)(2) The facility is considered to have a transfer agreement in effect if the facility has attempted in good faith to enter into an agreement with a hospital sufficiently close to the facility to make transfer feasible. This REQUIREMENT is not met as evidenced by: Based on interview and review of related documentation, it was determined that the facility failed to provide evidence of a written transfer agreement with one or more hospitals approved for participation under the Medicare and Medicaid programs. Findings include: The facility policy on transportation and	F 843	F843- Transfer Agreement A. No residents were affected by the deficient practice. B. All residents have the potential to be affected by the deficient practice. The facility has obtained a signed transfer agreement with a local hospital on 11/10/23.	

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F 843	Continued From page 189 appointments last updated 11/1/19, indicated, "A licensed nurse will ensure transportation to medically related appointments and will be responsible for coordinating those accommodations for transport as appropriate." The facility assessment last updated 9/2023 , lacked evidence of a transfer agreement with any hospital in the contracts and agreements section. During an interview on 9/25/23 at 1:40 PM, E1 (NHA) confirmed the facility was unable to provide a written transfer agreement between the facility and a hospital. E1 stated she thought transfer to hospital was indicated in the facility Assessmnet. 9/20/23 1:11 PM - A copy of the facility's written transfer agreement was requested from E1. No agreement was provided. 9/25/23 at 3:15 PM - Findings were reviewed with E1 (NHA) and E3 (DON).	F 843	C. A root cause analysis identified the facility did not have a transfer agreement with an area hospital. The RDCS/Designee will educate the Administrator on the requirement of having a transfer agreement with a local hospital to ensure safe and orderly transfers of residents. D. The Administrator/Designee will audit the transfer agreement located in the facility assessment binder weekly x 4 weeks until 100%, then every 2 weeks x 1 month until 100%, then monthly x 4 months until 100%. All audits will be submitted to the QAA committee monthly. The results of the audits will be reported X 4 months. The QAA committee will determine what, if any, additional intervention is needed at the end of the 4 months E. Date of completion: 11/30/2023	
F 849 SS=E	Hospice Services CFR(s): 483.70(o)(1)-(4) §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer.	F 849		11/30/23

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F 849	Continued From page 190 §483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate	F 849		

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F 849	Continued From page 191 course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation. (K) A delineation of the responsibilities of the	F 849		

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F 849	Continued From page 192 hospice and the LTC facility to provide bereavement services to LTC facility staff. §483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident. The designated interdisciplinary team member is responsible for the following: (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form.	F 849		

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F 849	Continued From page 193 (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by: Based on clinical record review and interview, it was determined that for four (R177, R178, R143 and 121) out of four residents reviewed for hospice, the facility failed to ensure a communication process was in place that hospice records were complete and readily accessible. In addition, the facility failed to ensure coordination and collaboration with hospice when R178 had an unplanned transfer and admission to the hospital on 11/25/23. In addition for R121 there was not an agreement in place for that provider. Findings include:	F 849	F849- Hospice Services A. R177, R178, and R143 no longer reside at the facility R121 continues to reside at the facility. Hospice records (I.e., care plan coordination, hospice nurse/aide visitation documentation, order change recommendation) have been obtained and will be maintained at the facility and the provider agreement is in place in a folder at the nursing station for all	

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F 849	Continued From page 194 1. Review of R177's clinical records revealed: 7/20/21 - R177 was admitted to the facility. 5/19/23 3:58 PM - A social service progress note documented, "Referral made to (hospice #1), hospice rep (representative) to reach out to daughter". 5/31/23 - R177 had an unplanned transfer to the hospital. 6/2/23 - A hospital discharge summary note documented, "...She (R177) was accepted by hospice to return to nursing home for services following hospital discharge...Continue outpatient care with hospice services in addition to nursing care long term facility...". 6/3/23 - R177 was readmitted to the facility. 6/4/23 2:56 PM - A nurse progress note documented, "...(Daughter) talked with nurse and decided she would rather have pa (patient) hospice care...". 6/5/23 10:06 AM - A social service noted documented, "...Most likely will go back on hospice care. referral (sic) made to (hospice #2)". 6/5/23 3:35 PM - A social worker note documented, "...Daughter met with (Hospice #2) rep to do eval (evaluation) to see if daughter wants hospice care again". Review of the nurse progress notes revealed the following documentation: 6/5/23 5:55 PM - "...Resident RP (Responsible	F 849	residents on hospice services. B. All residents of hospice services have the potential to be affected by this practice. DON/designee will audit all residents on hospice services to ensure that a hospice provider agreement will be on file and the facility will maintain hospice documentation. C. No policy changes are needed. Root cause analysis was completed, results identified in knowledge deficit regarding maintaining hospice documentation and obtaining provider agreements. DON/designee will educate licensed nursing staff on the location of the hospice folders, notification of resident transfer to the hospital, and expected documentation that will be maintained. The assigned nurse will review the hospice documentation after the visit and will communicate recommendations to the provider for further directions and hospice documentation will be maintained in a folder at the nursing station. UM will review hospice recommendations after visits to validate for provider follow-up prior to clinical meeting. D. DON/designee will audit resident on hospice services to ensure documentation is maintained on the units and provider agreements are obtained weekly X 4 weeks until 100%, then every 2 weeks X 1 month until 100%, then monthly X 4 months until 100%. All audits will be submitted to the QAA committee monthly. The results of the audits will be reported X 4 months. The QAA committee will determine what, if any, additional intervention is needed at the end of the 4	

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F 849	Continued From page 195 Party)/ NP (Nurse Practitioner) aware and hospice consult was ordered...". 6/6/23 4:34 PM - "Resident seen by (hospice #1) during shift for evaluation pending at this time...". 6/7/23 10:43 AM - "...(hospice #1) coming in today to speak with family...". 6/7/23 1:39 PM - "Resident seen by (Hospice#1) along with family...now on services...(hospice #1) nurse will visit today to see patient...". 6/9/23 9:54 AM - A social service progress note documented, "...Now on (hospice#1) hospice care". 8/1/23 2:00 PM - Further review of R177's clinical records lacked evidence of hospice #1 and hospice #2 documentation pertaining to hospice evaluation including plan of care and medication list. 9/1/23 10:52 AM - In an interview, E25 (SW) confirmed that she was not aware when hospice #1 started providing services to the resident. In addition, E25 stated, "I don't know about that. It's the family who directly contacted (hospice #1) and I was not aware of it. I will have to ask management to get access on their (hospice #1) notes and (hospice #2) evaluation notes." 9/6/23 2:20 PM - In an interview, R2 (RCD) confirmed, "We don't have resident's (R177) information available here in the facility but we can call them (hospice #1) and have them send over here the nurse and CNAs visit notes." 2. Review of R178's clinical records revealed: 10/5/22 - R178 was admitted to the facility with diagnoses including cancer of the prostate.	F 849	months. E. Date of completion: 11/30/2023	

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F 849	Continued From page 196 11/4/22 - R178 had a physician's order for hospice evaluation and treatment. 11/6/22 - R178's admission MDS assessment revealed that he was receiving hospice care services while a resident in the facility. 11/7/22 - A care plan was developed for R178's hospice/palliative care need due to cancer, terminal illness with interventions including but not limited to hospice staff to visit to provide care, assistance and evaluation... (hospice #2) to provide hospice care services. 11/25/23 - R178 had an unplanned transfer to the hospital. A hospital note, with a printed date 11/27/23, documented, "Patient with a metastatic bone cancer...was on hospice. will need assistance...to find out from NH (nursing home) what hospice agency patient was signed on to...patient with long term prognosis and hospice should be reinstated". 11/28/23 - A nurse progress note documented, "Face sheet, med list, careplans and facility initiated transfer/discharge letter faxed to (hospital) with positive transmission". 9/7/23 9:16 AM - In an email correspondence, surveyor asked E2 (RCD) for (hospice #2) documentation and if there was any documentation notifying (hospice #2) of R178's transfer to the hospital on 11/25/23. 9/7/23 9:17 AM - In an email correspondence, E2 responded, "We had to submit in writing our	F 849		

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F 849	Continued From page 197 request for the documents...'. 3. Review of R143's clinical record revealed: 7/31/23 - R143 was admitted to the facility with multiple diagnoses, including lung cancer and pneumonia. 8/3/23 - Physician's orders were written for a hospice consult for lung cancer and morphine sulfate solution 20 mg/ml, give 5 mg by mouth every 4 hours as needed for pain. 8/7/23 9:00 PM - A nursing progress note revealed that an on-call hospice staff visit was made because R143 was experiencing breathing difficulty. A recommendation from the on-call hospice nurse was made to change the timing of R143's morphine administration to morphine 5 mg by mouth every 4 hours routine, instead of every 4 hours as needed. 8/29/23 - A review of the facility Medication Administration Record (MAR) revealed that the morphine medication order that was present for R143 at the time of his discharge (death) was morphine 20 mg/ml, give 5 mg by mouth every 4 hours as needed for pain. 8/30/23 1:00 PM - During an interview, E3 (DON) confirmed that R143's had an on-call hospice visit on 8/7/23 evening during which H3 (RN Hospice) made a new medication recommendation to change the morphine medication administration from every 4 hours as needed, to every 4 hours routine administration, to address R143's breathing difficulties. E3 confirmed that the morphine medication timing change recommendation had not been acted upon by the	F 849		

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F 849	Continued From page 198 facility as evidenced by the lack of documented communication from the facility nurse who was caring for R143 at the time of the hospice on-call visit, to the facility on-call physician. E3 also confirmed that the facility on-call physician did not document that communication was received from the facility for a recommendation to change the timing of R143's Morphine administration, based on the hospice recommendation. 9/7/23 11:00 AM - During an interview, E22 (LPN Agency) the nurse who was assigned to R143 at the time of the 8/7/23 hospice on-call visit stated that she did not call the facility physician to communicate the hospice recommendation to change R143's morphine medication timings because R143's family did not want R143's morphine administration to be changed. 4. Review of R121's clinical record revealed.: 5/18/23 - Admitted to the facility. 5/19/23 - A History and Physical documented R121's stage III metastatic melanoma. 6/21/23 - Admitted to hospice care. A care plan last revised on 7/10/23, lacked evidence of a hospice care. 7/20/23 to 8/24/23 - Progress notes obtained from a hospice nurse (H4) documented the dates of R121's visits. The facility did not have the notes that detailed visits by H4. 8/16/23 11:52 AM - During the entrance conference with E1(NHA) the request for hospice agreement, and policies and procedures for each	F 849		

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F 849	Continued From page 199 hospice used. The facility failed to provide the hospice agreement providing services to R121. 8/29/23 10:00 AM - During an interview with H4 it was revealed that updates were shared with the facility nurse and the nurse wrote it down on a paper. H4 does not have access to R121's EMR to document the visits. It was further revealed that R121's supplies for treatment of skin cancer were delivered to the facility in R121's name and the facility signed for the delivery on 7/3/23, 7/17/23 and 7/21/23. Each week H4 reported that the wound care products never reached the patient despite the facility signing for the box that was addressed to R121. H4 had to have the wound care supplies delivered to the hospice office. The supplies for wound care finally reached R121 on 8/15/23. 9/8/23 at 11:30 AM - Findings were reviewed E1 (NHA), E2 (RCD) and E3 (DON).	F 849		
F 867 SS=F	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that	F 867		11/30/23

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F 867	Continued From page 200 are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;	F 867		

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F 867	Continued From page 201 (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.	F 867		

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F 867	Continued From page 202 §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure that the QAA committee measured the success of actions, track performance and regularly review, analyze, and act on data collected. Findings include: 9/8/23 11:10 AM - An observation of the facility's Quality Assurance Performance Improvement (QAPI) binder revealed the lack of a recent performance improvement project that the facility conducted which measured the success of actions, track performance and regularly review, analyze, and act on data collected. 9/8/23 11:15 AM - During an interview, E1 stated that the facility did not have a current or recent QAPI project to illustrate the facility's attempts at performance improvement. E1 stated that the facility was in the process of developing QAPI projects in the areas of staff recruitment and staff	F 867	F867- QAPI/QAA Improvement A. All residents may be potentially affected by deficient practice not identified for improvement by a quality improvement program. For this reason, Quality Assurance (QAPI/QAA) meetings were held on 8/22/23, 10/11/23, and 11/03/2023. B. The areas identified from the 8/22/23, 10/11/23 and 11/03/2023 QAPI/QAA meetings were that residents are at most risk for is inclusive of infection control, wound management, and resident falls. A performance improvement plan to collect, track and trend these areas for improvement has been initiated. C. A root cause analysis identified barriers to conducting QAPI/QAA	

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F 867	Continued From page 203 retention. 9/8/23 at 11:30 AM - Findings were reviewed with E1 (NHA), E2 (RCD) and E3 (DON).	F 867	committee meetings that identify and track areas for performance improvement. These barriers include a change of ownership in the past seven months and a new administrator who started employment on 5/17/2023. The onboarding process did not include a timely review of QAPI/QAA policy which includes the performance improvement process of measuring the success of actions, tracking performance, regular review, analyze, and actions based on data collected. The Administrator will be educated by the RDCS/Designee on ensuring a QAPI/QAA committee meets at least quarterly after the 11/03/2023 meeting. The facility will implement an efficient QAPI/QAA program that will analyze trended data collected from but not limited to adverse events, medications errors, quality of care, grievances, and infection control. From the data collected, the QAPI/QAA team will identify areas in need of improvements, forming action teams, setting goals, analyze the process, identifying root cause, and developing performance improvement plans. D. The QAPI/QAA Plan will be audited by the Administrator/designee monthly x 3 months until 100%. All audits conducted by the Administrator/DON will be submitted to the QAA committee monthly. All audits will be submitted to the QAA committee monthly. The results of the audits will be reported X 4 months. The QAA committee will determine what, if any, additional intervention is needed at the end of the 4 months.	

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F 867	Continued From page 204	F 867	E. Date of completion: 11/30/2023	
F 868 SS=E	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c) §483.75(g) Quality assessment and assurance. §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (iv) The infection preventionist. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (i) Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects required under the QAPI program, are necessary. §483.80(c) Infection preventionist participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality	F 868		11/30/23

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F 868	Continued From page 205 assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is not met as evidenced by: Based on a review of facility documentation, it was determined that the facility failed to conduct quarterly Quality Assurance Performance Improvement (QAPI) meetings and to maintain a QAPI committee of the required members. Findings include: 8/30/23 - A review of the facility QAPI meeting minutes for the last seven quarters revealed: Two meetings have taken place in the last seven quarters. There were no QAPI Meetings held in 2022. - Q4 2021 QAPI Meeting - The Medical Director was not present. - Q1 2023 QAPI Meeting - The Director of Nursing, the Medical Director and the Infection Preventionist were not present. 9/8/23 at 11:30 AM - Findings were reviewed with E1 (NHA), E2 (RCD) and E3 (DON).	F 868	F868- QAA Committee A. All residents may be potentially affected by deficient practice not identified for improvement by a quality improvement program. For this reason, Quality Assurance (QAPI/QAA) meetings were held on 8/22/23, 10/11/23, and 11/03/2023. Members in attendance included the Administrator, Director of Nursing, Therapy Manager, House Keeping and Maintenance Manager, Activity Director, Business Office Manager, Social Worker, Medical Records Manger, Staff Development/Infection Preventionist, and Dining Director. The medical director was invited but could not attend due to a schedule conflict B. The QAPI/QAA committee meeting established who the required committee members are and will meet at least quarterly. Invitations of other relevant members will be sent in advance to the Medical Director, Lab Representative and Pharmacy Consultant. C. A root cause analysis identified barriers to conducting QAPI/QAA committee meetings timely. These barriers include a change of ownership in the past seven months and a new administrator who started employment on 5/17/2023. The onboarding process did not include a timely review of QAPI/QAA	

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F 868	Continued From page 206	F 868	policy which includes the required members and the QAPI/QAA calendar/schedule to be implemented. The Administrator will educate staff on the required members of the committee to attend and provide a calendar for the quarterly QAPI/QAA meetings. In addition, the facility will conduct monthly QAA meetings as per company standards. The purpose and function of the QAA meetings is to develop and implement appropriate plans of action to correct any undesirable outcomes and monitor the effect of the implemented changes, revising plans as needed. D. The Administrator/Designee will monitor the quarterly meeting calendar and member attendance monthly x 3 months until 100%. All audits will be submitted to the QAA committee monthly. The results of the audits will be reported X 4 months. The QAA committee will determine what, if any, additional intervention is needed at the end of the 4 months. E. Date of completion: 11/30/2023	
F 880 SS=J	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	F 880		11/30/23

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F 880	Continued From page 207 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: §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	F 880		

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F 880	Continued From page 208 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. §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 interview and review of facility documentation as indicated, it was determined that the facility failed to implement their infection control program for COVID-19 after a resident on 8/4/23 tested positive and subsequent positives were identified on 8/15/23 and 8/19/23, putting residents at risk for a severe adverse outcome. On 8/22/23 at 4:40 PM, an Immediate Jeopardy (IJ) was called. Based on review of the facility's corrective actions, the IJ was abated on 8/23/23 at 3:00 PM. Additionally, the facility failed to maintain laundry services in a sanitary manner. Findings include: The facility's policy and procedure entitled "COVID-19", dated 5/10/23, stated, " ... 5. Containment/Management: a. Identification of a new case in a patient: ...	F 880	F880- Infection Control Corrective Action for those residents found to be affected by the alleged deficient practice R75, R144, R359, R130, and R358 were affected from the failure to initiate infection control plan for COVID-19. Medical Director was made aware of failure to initiate infection control plan for COVID-19, no further instructions noted. 8/22/2023 AD-HOC QAPI meeting was held to determine and review root cause analysis and corrective actions were implemented on initiating infection control program. 8/22/2023 Corrective Actions taken for residents with potential to be affected by alleged	

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F 880	Continued From page 209 -Initiate contact tracing and identify close contacts/exposures. -Serial testing of close contacts/exposures: -test immediately, if negative, test again 48 hr later, if negative, test again 48 hr later ... -If any new cases are identified, perform contact tracing for new case and initiate serial testing ... 7. Case Reporting ... b. Notify local and state health authorities of any diagnosed COVID-19 case ...". 1. Review of the facility's infection control line listing revealed the residents and the dates when each tested COVID-19 positive in the facility: 8/4/23 - R75; 8/15/23 - R359; and 8/19/23 - R130 and R358. 8/22/23 at 1:23 PM - During a combined interview, E3 (Interim DON/IP) and E4 (UM/RN) were asked if the facility conducted contact tracing and testing. E3 and E4 both stated that they did not conduct contact tracing and testing. 8/22/23 at 3:49 PM - During an interview, the Surveyor requested the facility's infection control line listing from E1 (NHA) as soon as possible. 8/22/23 at 4:40 PM - The facility management was notified that an Immediate Jeopardy was being called for the failure to implement their infection control program for COVID-19. The facility failed to do the following: -initiate contact tracing and identify close contacts/exposures; -conduct serial outbreak testing; -notify the Department of Public Health (DPH) of the COVID-19 outbreak as required; and -educate staff working in the building about the	F 880	deficient practice Infection Preventionist/designee initiated broad based testing for residents and staff. 8/22/2023 Administrator notified the Department of Public Health (DPH) of the COVID-19 outbreak 8/22/2023 Administrator/DON and Infection Preventionist educated by the Regional Director of Clinical Director on the COVID-19 infection control program, to include; initiation of contact tracing and identification of close contact/exposures, conducting serial testing, notifying DPH of the COVID-19 outbreak, and educating staff working in the building about the outbreak and the use of source control. 8/22/2023 Education of staff on COVID-19 outbreak and the use and availability of source control initiated. All staff will be educated and tested before their next scheduled shift. 8/22/2023 Administrator/designee will audit outbreak procedures weekly X 4 weeks until 100%, then every 2 weeks X 1 month until 100% then monthly X 4 months. All audits will be submitted to the QAA committee monthly. The results of the audits will be reported X 4 months. The QAA committee will determine what, if any, additional intervention is needed at the end of the 4 months. A. No Residents were identified B. All residents have the potential to be affected by this practice. Laundry Room doors were immediately closed C. Root cause analysis identified staff non-compliance with maintaining laundry	

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F 880	Continued From page 210 outbreak and the use of source control. 8/22/23 at 8:45 PM - The facility's abatement plan outlined the following corrective actions to be initiated immediately: -Infection Preventionist/designee initiated broad-based testing of COVID-19 for residents and staff. -Administrator notified the Department of Public Health of the COVID-19 outbreak. -Administrator/DON and Infection Preventionist educated by the Regional Clinical Director on the COVID-19 infection control program, to include: initiation of contact tracing and identification of close contact/exposures, conducting serial testing, notifying DPH of the COVID-19 outbreak, and educating staff working in the building about the outbreak and the use of source control. -Education of staff on COVID-19 outbreak and the use and availability of source control initiated. All staff will be educated and tested before their next scheduled shift. 8/23/23 at 4:43 PM - E1 (NHA) provided the Surveyor with evidence that DPH was notified of the COVID-19 outbreak, line listings were sent, and communication with DPH would continue on status of outbreak going forward. Review of the facility's staff education and testing documentation and follow-up interviews, the facility abated the immediate jeopardy as of 8/23/23 at 3 PM. 9/8/23 at 12:30 PM - Findings were reviewed with E1 (NHA), E2 (RCD) and E3 (Interim DON). 2. The laundry room tour on 8/21/23 at 10:00 AM revealed the following:	F 880	room door closure. Administrator/designee will provide infection control education regarding keeping the laundry room door closed at all times. Environmental director will round twice daily to ensure laundry room door securement. D. Administrator/designee will audit the laundry room door securement weekly x 4 weeks until 100%, then every 2 weeks x 1 month until 100%, then monthly X 4 months until 100%. All audits will be submitted to the QAA committee monthly. The results of the audits will be reported X 4 months. The QAA committee will determine what, if any, additional intervention is needed at the end of the 4 months. E. Date of completion: 11/30/2023	

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F 880	Continued From page 211 8/21/23 at 10:00 AM - The laundry room back door of the soiled linen room was propped open and not kept closed. Finding was reviewed and confirmed by E24 (Director of Housekeeping) on 8/17/23 at approximately 11:15 AM. 9/8/23 at 12:30 PM - Findings were reviewed with E1 (NHA), E2 (RCD) and E3 (Interim DON).	F 880		
F 887 SS=D	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects	F 887		11/30/23

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F 887	Continued From page 212 associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses; (v) The resident, resident representative, or staff member has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident; or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined that one (R136) out of five residents sampled for COVID-19 Immunization the facility failed to provide R136 education for COVID-19. In addition, R136's clinical record lacked evidence that R136 had consented or declined to be given the COVID-19 vaccination. Findings include:	F 887	F887- Covid-19 Immunization A. R136 continues to reside at the facility and has been presented the education for the COVID-19 vaccination. She wishes to get the COVID-19 vaccination. Will administer upon delivery from the pharmacy.	

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F 887	Continued From page 213 Review of R136's clinical record revealed: 6/12/23 - R136 was admitted to the facility with a diagnosis of schizoaffective disorder bipolar type. 9/5/23 - Review of R136's record lacked evidence of COVID-19 immunization. In addition, R136 had not been provided an informed consent and or declination for COVID-19. 9/6/23 1:35 PM - An email from E2 (RCD) confirmed that R136 had not been provided education for the COVID-19 vaccination and that a consent and or declination form had not been found in R136's clinical record. 9/8/23 11:30 AM - Findings were reviewed with E1 (NHA), E2 (RCD) and E3 (DON).	F 887	B. All residents that have not received the COVID-19 vaccination have the potential to be affected by this practice. The Infection Control Practitioner will audit of all residents who have not received the COVID-19 vaccination to provide education on vaccination to identified resident, administer and document if the resident consents or document declination if resident refuses. C. Root cause analysis completed results identified that the facility failed to follow the COVID-19 Vaccination policy. Upon admission (the admission nurse) and per administration frequency guidelines, the resident will be offered applicable immunizations if they have not yet received them or are due for the immunization. The resident will be provided education on the immunization via the Vaccine Immunization Statement. If the resident consents to the immunization, it will be administered per order and documented in the medication record. If they decline the immunization, the declination will be recorded in the record. New admission chart checks will also review for documentation of accepting/declining applicable vaccinations. RDSC will educate all licensed nurses on the policy regarding COVID-19 Vaccination and record keeping. D. IP/designee will audit 5 residents for COVID-19 education and consent/declination of vaccine weekly X 4 weeks until 100%, then every 2 weeks X 1 month until 100%, then monthly X 4 months until 100%. All audits will be	

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F 887	Continued From page 214	F 887	submitted to the QAA committee monthly. The results of the audits will be reported X 4 months. The QAA committee will determine what, if any, additional intervention is needed at the end of the 4 months. E. Date of completion: 11/30/2023	
F 943 SS=F	Abuse, Neglect, and Exploitation Training CFR(s): 483.95(c)(1)-(3) §483.95(c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- §483.95(c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. §483.95(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property §483.95(c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on record review it was determined that for five (E40, E66, E87, E88 and E89) out of five employees sampled the facility failed to provide abuse, neglect, exploitation, and dementia training at least annually for E87 and E88. Findings include: The facility was provided a list of five names selected randomly and instructed to provide	F 943	F943- Abuse, Neglect, and Exploitation Training A. There were no residents affected by this deficient practice. B. All residents have the potential to be affected by this deficient practice. C. A root cause analysis identified the facility did not have a process in place to track and monitor adherence to required	11/30/23

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F 943	Continued From page 215 documentation of in-service training for abuse, neglect, exploitation, and dementia training for new and existing staff. 9/20/23 1:29 PM - An email communicated to E1 (NHA) requested training records for E40 (RN), E66 (LPN), E87 (LPN), E88 (CNA) and E89 (SS). 9/25/23 10:36 AM - A second email communicated to E1 (NHA) requested training records for E40, E66, E87, E88 and E89. 9/25/23 11:39 AM - An email communication from E1 stated, "we do the training verbally." 9/25/23 11:43 AM - An email sent to E1 requested, "an outline of trainings that had been done verbally." 9/25/23 11:45 AM - E1 communicated and confirmed in another email "I do not have them." 9/25/23 12:45 PM - Review of a training schedule titled 'Relias Learning Module Assignments"dated 2023 MFA documented ...Monthly training modules from 1/1/2023 through 12/31/2023. 9/25/23 1:05 PM - In a brief interview E1 said, "the company changed hands around February 1, 2023, and moving forward Relias module assignments will be started and scheduled. In addition, E1 revealed, "Relias modules had not started because of timing and change in ownership." The facility failed to provide purposeful training requirements for all staff providing direct and indirect care and services for the residents.	F 943	staff training for abuse, neglect, and exploitation for direct and indirect care and services for the residents. In addition to E40, E66, E87, E88 and E89, all facility staff will be educated on regulation F943. A 100% audit of employee files will be conducted by the Human Resources Director/Designee. The Administrator will educate the Human Resources Director and Staff Development Coordinator on ensuring that all new and existing staff meet the trainings requirements as set forth by CMS. The Human Resources Director will generate a report monthly to validate adherence to the training requirements for F943. SDC will ensure the identified staff are notified of missed education. If any active employee is found not in compliance, the employee, the DON and the Administrator will be notified. Failure of staff to adhere to the expected requirements will be subjected to progressive discipline. D. The Human Resources Director/Designee will audit 10 existing and 3 newly hired employee files weekly x 4 weeks until 100%, then every 2 weeks x 1 month until 100%, then monthly x 4 months until 100%. All audits conducted by the Human Resources Director/Designee will be submitted to the QAA committee monthly. All audits will be submitted to the QAA committee monthly. The results of the audits will be reported X 4 months. The QAA committee will determine what, if any, additional intervention is needed at the end of the 4 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085033	A. BUILDING _____ B. WING _____	C 09/25/2023

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F 943	Continued From page 216 9/25/23 3:15 PM - Findings were reviewed with E1 (NHA) and E2 (DON).	F 943	E. Date of completion: 11/30/2023	
F 944 SS=F	QAPI Training CFR(s): 483.95(d) §483.95(d) Quality assurance and performance improvement. A facility must include as part of its QAPI program mandatory training that outlines and informs staff of the elements and goals of the facility's QAPI program as set forth at § 483.75. This REQUIREMENT is not met as evidenced by: Based on record review it was determined that for five (E40, E66, E87, E88 and E89) out of five employees sampled the facility failed to provide QAPI (Quality Assurance Process Improvement) training at least annually. Findings include: The facility was provided a list of fives names selected randomly and instructed to provide documentation of in-service training for QAPI for new and existing staff. 9/20/23 1:29 PM - An email communicated to E1 (NHA) requested training records for E40 (RN), E66 (LPN), E87 (LPN), E88 (CNA) and E89 (SS). 9/25/23 10:36 AM - A second email communicated to E1 (NHA) requested training records for E40, E66, E87, E88 and E89. 9/25/23 11:39 AM - An email communication from E1 stated, "we do the training verbally." 9/25/23 11:43 AM - An email sent to E1 requested, "an outline of QAPI training that had been done verbally."	F 944	F944- QAPI Training A. No residents were affected by the deficient practice. B. All residents have the potential to be affected by the deficient practice. C. A root cause analysis identified the facility did not have a process in place to track and monitor adherence to required staff training for staff providing direct and indirect care and services for the residents. In addition to E40, E66, E87, E88 and E89, all facility staff will be educated on regulation F944. A 100% audit of employee files will be conducted by the Human Resources Director/Designee. The Administrator will educate the Human Resources Director and Staff Development Coordinator on ensuring that all new and existing staff meet the trainings requirements as set forth by CMS. The Director of HR will generate a monthly report to validate adherence to the training requirements for F943. SDC will ensure the identified staff are notified of missed	11/30/23

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