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

DHSS - DHCQ
261 Chapman Road Suite 200
Newark, DE 19702

STATE SURVEY REPORT

NAME OF FACILITY: Pike Creek Nursing & Rehabilitation Center DATE SURVEY COMPLETED: December 22, 2023

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced Follow Up, Complaint and Emergency Preparedness survey was conducted at this facility from December 11, 2023 through December 22, 2023. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census on the first day of the survey was 148. The sample totaled 36 residents. Abbreviations/Definitions used in this report are as follows: BCC – Background Check Center; DON – Director of Nursing; NHA – Nursing Home Administrator; LPN – Licensed Practical Nurse; RN – Registered Nurse; and		
3201	VPO – Vice President of Operations. **Regulations for Skilled and Intermediate Care**		
3201.1.0	**Facilities**		
3201.1.2	**Scope** **Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation,**		

Rebecca J. White, NHA 1/12/24

Provider's Signature _Rebecca White ___ _Title__LNHA_____Date _1/12/2024_____

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	as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.		
	This requirement is not met as evidenced by:	3201.1.2	
	Cross Refer to the CMS 2567-L survey completed 12/22/23: F580, F656, F657, F684, F690, F695, F698, F730, F756, F761, F804, F842 and F849.	Cross Refer to the CMS 2567-L survey completed 12/22/23: F580, F656, F657, F684, F690, F695, F698, F730, F756, F761, F804, F842 and F849.	1/29/2024
3201.3.0	General Requirements		
3201.3.4	Inspections and monitoring by the Division shall be carried out in accordance with 16 Delaware Code, §1107.		
3201.3.10	The nursing facility shall cooperate fully with the state protection and advocacy agency, as defined in 16 Del.C. §1102(7), in fulfilling functions authorized by Title 16, Chapter 11.		
	16 Del. C.: Health and Safety		
	Chapter 11: Long-Term Care Facilities and Services		
	Subchapter I: Licensing By The State		
	§ 1107: Inspections and monitoring.		
	(c) Any duly authorized employee or agent of the Department may enter and inspect any facility licensed under this chapter without notice at any time. All licensees are required to provide immediate access to Department personnel to conduct inspections. Such inspections may include any of the following:		

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	3) Reviewing and photocopying any records and documents maintained by the licensee. **These requirements were not met as evidenced by:** Based on interview, record reviews and requests by the Survey Team, it was determined that the facility failed to provide the Survey Team with immediate access to the facility records. Findings include: 1a. 12/18/23 1:44 PM – An email was sent to facility administration requesting the facility's incident report of R35's unwitnessed fall to the Survey Team. A verbal request was also made at 3:00 PM. 1b. 12/19/23 10:00 AM – An email was sent to the facility administration requesting the facility's incident report of R6's 12/5/23 unwitnessed fall to the Survey Team. A verbal request was also made at 10:30 AM. 12/21/23 4:00 PM – During an interview with E16 (VPO), the Survey Team communicated that requests had been made for the facility to provide the facility incident reports for both R6 and R35, and as of this date the reports still had not been provided to the Survey Team. 12/22/23 9:30 AM – The facility incident reports were provided to the Survey Team, three to four days after the initial requests were made. The facility failed to provide the Survey Team with immediate access to facility records.	**3201.3.10 Access to records** A. No residents were affected by the deficient practice. R6 and R35's incident reports were provided to the surveyors. B. All residents have the potential to be affected by the deficient practice. An audit was conducted to ensure that all incident reports are readily available for immediate access to Department personnel to conduct inspections. C. A root cause analysis identified the facility did not have an organized system in place to ensure incident reports are retrieved for immediate access to all Department employee(s) or agent for inspections and monitoring purposes. All incident reports are now in date order of the incident and kept in the DON office. The Administrator and DON will be educated by the Regional Director of Clinical Services on providing immediate access to incident reports. D. The Administrator/DON will audit all incident reports from the last 30 days to ensure 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	1/29/2024

Rebecca White, NHA 1/12/24

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		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 3 months. E. Date of completion: 1/29/2024	
3201.5.0 3201.5.5	Personnel/Administrative The facility shall have written personnel policies and procedures. Personnel records shall be kept current and available for each employee, and include the following: -Results of tuberculosis screening.		
3201.5.5.1	This requirement was not met as evidenced by: Based on interview and review of facility documentation provided to the Surveyor, it was determined that for two (2) out of three employees reviewed, the facility's personnel records lacked evidence of tuberculosis (infectious lung disease) screening results. 12/15/23 at 1:15 PM – Review of facility documentation provided to the Surveyor revealed the employees below lacked evidence of 2-step tuberculosis screening. No further information was provided to the Survey Team. -E32 CNA -E33 LPN	3201.5.5.1 Personnel/Administrative-Results of tuberculosis screening A. No residents were affected by the deficient practice. B. All residents have the potential to be affected by the deficient practice. An audit of all new and existing employees will be conducted to ensure all new and existing employees/contractors have a completed 2-step tuberculosis screening. C. A root cause analysis identified the facility did not have a process in place while in the absence of a human resources director to ensure all new hires/contract staff had completed these requirements. A new human	1/29/2024

Rebecca White 1/12/24

Provider's Signature _Rebecca White ___ _Title__LNHA_____Date _1/12/2024_____

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SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
		resources director will begin employment on 1/15/24 and will be educated on this requirement for all new hires/contract staff. The facility will have a process put in place to ensure that in the absence of a Human Resources Director, the facility will have a backup person(s) to complete the process. D. The Human Resources Director/Designee will audit 10 existing and 3 newly hired employee files for compliance weekly x 2 weeks until 100%, then every 2 weeks x 1 month until 100%, then monthly x 2 months until 100%. All audits conducted by the Human Resources Director/Staff Development Coordinator 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: 1/29/2024	
	-Results of criminal background check		
3201.5.5.3	-Results of mandatory drug testing		
3201.5.5.4	-Result of Adult Abuse Registry check.		
3201.5.5.5	These requirements were not met as evidenced by:		

Rebecca White 1/24/24
Provider's Signature _Rebecca White___ Title LNHA Date 1/12/2024

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	Based on interview and review of facility documentation provided to the surveyor, it was determined that for one (1) out of three employees reviewed, the facility's personnel records lacked evidence of criminal background checks, mandatory drug testing and adult abuse registry checks. Findings include: 12/15/23 at 1:15 PM – Review of facility documentation provided to the Surveyor revealed the employees below lacked evidence of criminal background check, pre-employment drug test and the adult abuse registry check. No further information was provided to the Survey Team. -E32 CNA: not listed in the BCC; no criminal background check, drug test and adult abuse registry check. -E34 LPN: the criminal background check, drug test and adult abuse registry check were after the date of hire.	**3201.5.5.3, 3201.5.5.4, 3201.5.5.5 Results of criminal background check, mandatory drug test, and Adult Abuse Registry Check** A. No residents were affected by the deficient practice. B. All residents have the potential to be affected by the deficient practice. An audit of all new and existing employees/contractors will be conducted to ensure results of criminal background checks, mandatory drug tests, and adult abuse registry check are completed and maintained in the employee records. C. A root cause analysis identified the facility did not have a process in place while in the absence of a human resources director to ensure all new hires/contract staff had completed these requirements. A new human resources director will begin employment on 1/15/24 and will be educated on this requirement for all new hires/contract staff. The facility will have a process put in place to ensure that in the absence of a Human Resources Director, the facility will have a backup person(s) to complete the process. D. The Human Resources Director/Designee will audit 10 existing and 3 newly hired employee files for compliance weekly x 2 weeks until 100%, then every 2 weeks x 1	1/29/2024

Rebecca White 1/15/24

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		month until 100%, then monthly x 2 months until 100%. All audits conducted by the Human Resources Director/Staff Development Coordinator 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: 1/29/2024	
3201.9.0 3201.9.5	**Records and Reports** **Incident reports, with adequate documentation, shall be completed for each incident. Adequate documentation shall consist of the name of the resident(s) involved; the date, time and place of the incident; a description of the incident; a list of other parties involved, including witnesses; the nature of any injuries; resident outcome, and follow-up action, including notification of the resident's representative or family, attending physician and licensing or law enforcement authorities, when appropriate.** **This requirement was not met as evidenced by:** Based on record review and interview, it was determined that for two (R6 and R35) out of three residents reviewed for falls, the facility failed ensure that incident reports were complete with adequate documentation including a list of other parties involved.	**3201.9.0, 3201.9.5 Records and Reports** A. No residents were affected by the deficient practice.	1/29/2024

Rebecca White 1/15/24

Provider's Signature _Rebecca White___ _Title__LNHA_____Date _1/12/2024_____

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	Findings include: 1. Review of R6's record revealed: 12/11/23 - R6 experienced an unwitnessed fall on 12/5/23 at 8:00 PM and was transported to the hospital emergency department. 12/22/23 9:30 AM – The facility incident report was supplied to the Survey Team; the facility investigation did not contain a written statement from the nurse that found the resident after the fall. E1 (NHA) confirmed that there were no other facility investigative documents for R6's 12/5/23 unwitnessed fall. 2. Review of R35's record revealed: 12/11/23 – R35 experienced an unwitnessed fall on 11/30/23 at 9:20 PM and was transported to the hospital emergency department. 12/22/23 – The facility's incident report lacked documentation that R35's responsible party was notified of R35's transfer to the hospital.	8. All residents have the potential to be affected by the deficient practice. An audit of incident reports from the last 30 days will be completed to ensure the reports are complete with adequate documentation, including a list of other parties included. C. A root cause analysis identified the facility failed to ensure that an incident report was completed with adequate documentation including a list of other parties involved for R6 and R35, and the facility failed to ensure that the incident report was retained. The RDCS will reeducate the Administrator and DON on the state regulatory requirements for records and reports. D. The Administrator/DON will audit all incident reports from the last 30 days to ensure 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 determine what, if any, additional intervention is needed at the end of the 3 months. E. Date of completion: 1/29/2024	

Rebecca White 1/15/24

Provider's Signature _Rebecca White ___ _Title_LNHA_____Date _1/12/2024_____

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3201.9.6	All incident reports whether or not re-quired to be reported shall be retained in facility files for three years. Reportable incidents shall be communicated immediately, which shall be within eight hours of the occurrence of the incident, to the Division of Long Term Care Residents Protection.		
3201.9.7	Incident reports which shall be retained in facility files are as follows:		
3201.9.7.1	All reportable incidents as detailed below.		
3201.9.8.4	Significant injuries.		
3201.9.8.4.2	Injury which results in transfer to an acute care facility for treatment or evaluation or which requires periodic neurological reassessment of the resident's clinical status by professional staff for up to 24 hours. These requirements were not met as evidenced by: Based on record reviews and interview, it was determined that for two (R6 and R35) out of three residents reviewed for falls, the facility failed to report falls with injuries to the State Agency within eight hours of the occurrence. Findings include: 1. Review of R6's record revealed: 12/11/23 - R6 experienced an unwitnessed fall on 12/5/23 at 8:00 PM and was transported to the hospital emergency department. The facility did not report the fall to the State Agency	3201.9.8.4.2 Reporting of Falls with Injury A. No residents were affected by the deficient practice. B. All residents have the potential to be affected by the deficient practice. The NHA reported the falls for R6 and R35 upon discovery. C. A root cause analysis identified that the facility nursing staff did not make administration aware of the incidents in a timely manner. The Staff Development Coordinator will educate all licensed nurses on reporting falls	1/29/2024

Rebecca White 1/15/24
Provider's Signature _Rebecca White___Title_LNHA_____Date _1/12/2024_____

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	within 8 hours, until 12/6/23 at 5:11 PM, 21 hours after the fall occurred. 2. Review of R35's record revealed: 12/11/23 – R35 experienced an unwitnessed fall on 11/30/23 at 9:20 PM and was transported to the hospital emergency department. The facility did not report the fall to the State Agency within 8 hours, and not until 12/1/23 at 12:56 PM, 16 hours after the fall occurred. 12/22/23 1:30 PM - Findings were reviewed with E1 (NHA), E16 (VPO) and E21 (DON	with injury to the DON/NHA immediately to ensure timely reporting to the Department. D. The Administrator/DON will audit all falls with injury from the last 30 days to ensure 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 determine what, if any, additional intervention is needed at the end of the 3 months. E. Date of completion: 1/29/2024	

Rebecca White 1/15/24

Provider's Signature _Rebecca White___ Title LNHA Date 1/12/2024

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 _____	R-C 12/22/2023

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
{E 000}	Initial Comments	{E 000}		
{F 000}	INITIAL COMMENTS An unnanounced Follow-up Survey to the Annual, Complaint, Emergency Preparedness and Extended Survey ending 9/25/23 was conducted by the State of Delaware Division of Health Care Quality, office of Long Term Care Residents protection on December 11,2023 thru December 22, 2023. The facility census on the first day of the survey was one-hundred and forty eight (148). The sample size was thirty-six (36) residents. The facility was found to not be in substantial compliance with 42 CFR Part 483, Subpart B, Requirments for Long Term Care as of December 22, 2023. Abbreviations/definitions used in this report are as follows: Anemia - reduced ability of red blood cells to carry oxygen to organs causing tiredness; AV shunt (arteriovenous shunt) - surgical connection of a vein and an artery for dialysis; Bruit/Thrill - assessment of sound and feeling when blood flows in the AV shunt; CNA - Certified Nursing Assistant; Dehydration - a condition when the body has less than normal fluid; Dialysis - a process to remove toxins from the blood when the kidneys have failed; EMR - Electronic Medical Record; Foley Catheter - tube held in the bladder by a small balloon to drain urine; G (gram) - metric unit of weight, 1g equals 1000 mg;	{F 000}		

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

Electronically Signed | 01/12/2024

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

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{F 000}	Continued From page 1 Mg (milligrams) -unit of weight, 1 mg equals 0.0035 ounce; LPN - Licensed Practical Nurse; MDS (Minimum Data Set) - standardized assessment forms used in nursing homes; mL (milliliters) -unit of liquid volume, 5 ml equals 1 teaspoon; NP - Nurse Practitioner; Systolic Pressure - top number of the blood pressure reflecting pressure in vessels when the heart is beating; UM - Unit Manager. Fall Risk Scoring Tool: High Risk- greater that or equal to 12; Moderate Risk - 10-11 Low Risk - 9 and under.	{F 000}		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the	F 580		1/29/24

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F 580	Continued From page 2 resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R35) out of three residents reviewed for notification of changes, the facility failed to notify R35's emergency contact when R35 fell and was transferred to the hospital. Findings include: Review of the facility policy titled, Documentation	F 580	F580- Notify of changes. A. R35 no longer resides at the facility. B. All residents with a change in condition have the potential to be affected. DON/unit manager will audit the last 14 days of change in conditions to verify emergency contact or responsible party were notified of change in condition. If	

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F 580	Continued From page 3 and Notification, effective 11/01/19, Procedure #1: "The Charge Nurse is responsible for notifying the Physician (MD) and/or the Responsible Party (RP) whenever there is a change related to the care of the patient. Notification will occur when there is a: ... -Fall -New order requiring the patient to leave the Center for a treatment or diagnostic test ... ". Review of R35's clinical record revealed: 11/30/23 - A progress note written in the EMR revealed that R35 fell in her room and hit her head during the fall. A physician's order was written by E5 (MD) to transfer R35 to the hospital to be evaluated. R35 was subsequently admitted to the hospital. The following interviews were obtained on 12/15/23: -8:30 AM - During an interview, E11 (Director of Social Services) confirmed that the clinical record lacked documentation that R35's emergency contact was notified when R35 was transferred to the hospital. -10:30 AM - During an interview, E3 (DON) stated that she became aware of the facility's lack of communication to R35's responsible party when E3 spoke to R35's son (F1) on the telephone on 12/6/23 and F1 stated that he never knew that his mother was sent to the hospital on 11/30/23. E3 confirmed that the clinical record lacked documentation that R35's emergency contact was notified when R35 was transferred to the hospital on 11/30/23.	F 580	they were not notified, notification will be made by the DON or Unit manager. C. A root cause analysis identified the staff misunderstood the requirements to call family when the resident is their own responsible party. When a resident has a change in condition, the nurse assigned to them is responsible for notifying the emergency contact and/or responsible party. The unit manager and/or charge nurse is to verify that contact has been made prior to the end of the shift when the change of condition occurred. Resident change in condition RP notification will be confirmed during clinical meeting daily. The staff developer will educate licensed nurses on notification of emergency contact and/or responsible party after a change in condition. D. The DON/Unit manager will audit 100% or up to 10 residents with change of condition to ensure notification was made to responsible party and/or emergency contact weekly x 4 weeks until 100% compliance, then every 2 weeks x 1 month until 100% compliance, then monthly x 4 months until 100% compliance. 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: 1/29/2024 Audit tool and results were emailed by Administrator.	

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F 580	Continued From page 4 -1:15 PM - During an interview E12 (RN UM) stated that she was on vacation on 11/30/23, when R35 was transferred to the hospital, and that E12 did not know who was supposed to place the communication call to R35's emergency contact in E12's absence. E12 confirmed that subsequent chart checks of R35's clinical record failed to reveal that R35's emergency contact was ever notified of her fall and her transfer to the hospital on 11/30/23. 12/22/23 1:30 PM - Findings were reviewed during the exit conference with E1 (NHA), E16 (VPO) and E21 (DON).	F 580		
{F 656} SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized	{F 656}		1/29/24

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{F 656}	Continued From page 5 rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for two (R12 and R22) out of three residents sampled for care plans, the facility failed to ensure that R12's care plan reflected his use of a blood thinner and R22's care plan included her fluid restrictions. Findings include: 1. Review of the clinical record revealed: 10/26/23 - R12 was admitted to the facility with diagnoses including a broken of the right ankle. R12's medications included heparin sodium solution 5000 units/ml (blood thinner) - inject 1 ml every 12 hours to prevent blood clots.	{F 656}	F656- Develop/Implement Comprehensive Care Plan A. 1. R12 still resides at the facility. The Blood thinner medication has been discontinued; the resident no longer needs a care plan for blood thinner medications. 2. R22 still resides in the facility. A fluid restriction order has been entered in the medical records and the care plan indicates the fluid restrictions plan. B.	

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{F 656}	Continued From page 6 12/12/23 - A review of R12's EMR lacked evidence of monitoring for adverse effects of the blood thinner including bruising, and or bleeding. R12's records also failed to show evidence for a care plan to monitor for adverse effects of this medication. 12/12/23 2:00 PM - Findings were confirmed with E4 (SD/IP). 2. Review of the clinical record revealed: 3/28/23 - R22 was admitted to the facility with diagnoses including End Stage Renal Disease (ESRD). R22's orders included dialysis treatment three times a week on Tuesday, Thursday, and Saturday. 3/28/23 - R22's care plan included, "...Observe for signs and symptoms of complications related to ESRD including fluid overload...". 12/15/23 - A review of R22's EMAR failed to reveal evidence of an order for fluid restrictions or monitoring. R22's records failed to show evidence of a care plan for fluid restrictions. 12/19/23 12:30 PM - Findings were confirmed with E1 (NHA), E7 (Dietitian), and E13 (LPN Unit Manager).	{F 656}	1. All residents on blood thinner medications have the potential to be affected. DON/Unit managers will complete an audit on residents who are on blood thinners to ensure monitoring is in place for adverse effects and to ensure care plan includes monitoring for adverse effects. 2. All residents on dialysis and/or with a fluid restriction have the potential to be affected. DON/Dietitian will audit all residents who receive dialysis and/or have a fluid restriction to determine if fluid restriction is ordered and ensure it is care planned. If it is not ordered, the provider will be notified to determine if a fluid restriction is needed. C. 1.Root cause analysis determined that R12 was admitted on a blood thinner medication, and the admission assessment did not capture blood thinners which would trigger the care plan. The admission assessment has been revised in the EMR to include blood thinners and trigger care plans to monitor adverse reactions to this medication type. Licensed nursing staff will be educated by the DON/Designee on the new admission assessment and timely creation/updating of care plans. 2. Root cause analysis determined that for R22, there was not a process to confirm fluid restriction orders at the time of admission. The dietitian will reach out to the dialysis center, if a dialysis resident does not have a fluid restriction ordered to get clarification of if fluid restriction order	

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{F 656}	Continued From page 7	{F 656}	is necessary. Dietitian will be educated on revised workflow for ascertaining fluid restrictions. Any communication regarding a change in resident□s plan of care between the dietician and dialysis center will be documented in the dietician progress note. D. DON/Designee will audit all new resident and residents with fluid restrictions and blood thinners orders to ensure care plan has been created/updated promptly weekly x 4 weeks until 100% compliance, then every 2 weeks x 1 month until 100% compliance, then monthly x 4 months until 100& compliance. 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: 1/29/2024	
{F 657} SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident.	{F 657}		1/29/24

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{F 657}	Continued From page 8 (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R26) out of three residents reviewed for care plans, the facility failed to revise R26's resident centered care plan. Findings include: Review of R26's clinical record revealed: 12/1/23 - R26 began to receive hospice care. 12/15/23 - A review of R26's care plan revealed a 12/1/23 care problem that R26 was receiving hospice care and that the hospice was to provide a bath or shower aide for R26's care. 12/18/23 11:15 AM - During an interview, E13 (LPN UM) stated that R26 did not have a hospice aide that provided a bath or shower. E13 confirmed that R26's current care plan documented the hospice was to provide a bath or	{F 657}	F657- Care Plan Timing and Revision A. R26 still resides in the facility. Their care plan was updated to accurately reflect coordination of hospice care. B. A review of all residents on hospice care plans will be completed to ensure the care plan matches the coordination of care that hospice provides. Any discrepancies will be corrected. C. Root cause analysis completed, and it identified lack of process for coordination of care to accurately reflect on the residents' personalized care plan between Hospice and facility. Unit Manager/Social Services will be educated on coordinating Hospice care plans with facilities plan of care. D. MDS/Designee will audit care plans on residents on hospice to ensure their coordination of care and in house care	

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{F 657}	Continued From page 9 shower aide for R26's care. 12/22/23 1:30 PM - Findings were reviewed with E1 (NHA), E16 (VPO) and E21 (DON).	{F 657}	plans match and accurately reflect care provided to the resident weekly x 4 weeks until substantial compliance, then every 2 weeks x 1 month until substantial compliance, then monthly x 4 months until substantial compliance. 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: 1/29/2024	
{F 684} SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, record review, interview and review of documentation as indicated, it was determined that for one (R31) out of three residents reviewed for bowel and bladder, the facility failed to ensure that R31 received medications for constipation. For two (R12 and R18) out of two residents sampled for medication administration, the facility failed to ensure that R12 and R18 received their medications as prescribed by their physicians. Findings include:	{F 684}	F684 1. A. R 31 does not require medications for constipation. Staff interviews revealed that resident R 31 toilets self and is a poor historian when asked if she had moved her bowels. She had no abdominal distention, pain or signs or symptoms of constipation. B. All residents can be affected by this	1/29/24

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{F 684}	Continued From page 10 1. Review of R31's record revealed: 9/28/23 - R31 was admitted to the facility with multiple diagnoses including stroke, hypertension, rib fractures from a recent car accident and delirium. 9/28/23 - Physician's orders were written for the following medications: -Milk of Magnesia 400 mg/5 ml, give 30 ml by mouth every 24 hours as needed for constipation if no bowel movement in three days. -Biscolax Suppository 10 mg, insert 1 suppository rectally as needed for constipation if milk of magnesia is ineffective. -Fleet enema 7-9 gram/118 ml, insert 1 unit rectally every 24 hours as needed for constipation. Use only if Biscolax suppository is ineffective. 10/4/23 - R31's MDS admission assessment documented the following information regarding R31: -Toileting hygiene: 3, indicating that R31 needed partial to moderate assistance. -Bowel Incontinence: 2, indicating that R31 was frequently incontinent. 12/15/23 - A review of the bowel task report in the EMR revealed that R31 did not have a bowel movement for more than three days, from 12/12/23 at 11:37 PM thru 12/16/23 at 1:38 PM. A review of R31's medication administration record revealed that R31 did not receive any of the above medications for constipation. 12/19/23 - During an interview E4 confirmed that R31's bowel task report did not have a bowel	{F 684}	deficient practice. DON/designee will review all residents EMR to identify residents who need their care plan updated to appropriately reflect the need to ask residents if they had a bowel movement. C. A root cause analysis was conducted, and it was determined staff were not asking residents who self-toilet if they moved their bowels or not. Nurses were clearing the clinical alerts for no BM X 3 days, after confirming with residents that they had a BM without writing a progress notes. The DON/designee will educate CNAs to ask resident who toilet themselves if they had bowel movements and document in the EMR. The DON/designee will educate the nursing staff to the need to document in the EMR progress notes after clearing alerts. D. The DON/designee will audit residents not having BM in 3 or more days to ensure appropriate intervention initiated or progress note entered for cleared alerts weekly x 4 weeks until 100% compliance, then every 2 weeks x 1 month until 100% compliance, then monthly x 4 months until 100% compliance. Results from audits will be brought to monthly QAPI meeting for review and further recommendations. 2. A. R12 and R18 R12 Heparin medication has been discontinued. R18 Renvela medication has been discontinued. B. All residents have the potential to be affected by this practice. DON/designee	

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{F 684}	Continued From page 11 movement documented for 12/12/23 thru 12/16/23. The facility failed to ensure that R31's bowel activity was accurately monitored from 12/12/23-12/16/23. 2. 10/26/23 - R12 was admitted to the facility with diagnoses including a broken of the right ankle. R12's medications included heparin sodium solution 5000 units/ml (blood thinner) - inject 1 ml every 12 hours to prevent blood clots. 12/10/23 - A review of R12's EMR revealed the 8:00 PM dose of heparin sodium was not administered. 12/12/23 2:00 PM - Findings were confirmed with E4 (SD/IP). 3. 8/22/23 - R18 was admitted to the facility with diagnoses including end stage renal disease (ESRD) and dependance on renal dialysis (a process to remove toxins from the blood when the kidneys have failed). R18 was scheduled to be picked up from the facility at 5:00 AM for dialysis treatments on Tuesday, Thursday, and Saturday. 8/22/23 - R18's EMR included, "Renvela 800mg (a medication used to control phosphorus levels in the blood for patients with chronic kidney disease) give one tablet three times a day before meals, at 9:00 AM, 1:00 PM and 9:00 PM." 12/20/23 12:15 PM - A review of R18's EMR revealed missed doses of Renvela 800 mg at 9:00 AM on 12/5/7/12/14/19/23 (a total of 5 doses). During an interview with E12 (Unit	{F 684}	conduct a 14-day review of residents EMAR to identify any missed medication, the residents□ provider will be notified of any missed medication for further instructions. Residents□ receiving dialysis services will have their medications administration times reviewed by DON/designee to ensure that any medication scheduled to be administered when resident is receiving dialysis out of the building will be rescheduled if possible. C. A root cause analysis was conducted, and it was determined that R18 licensed nurses failed to identify the need to reschedule medication administration times to accommodate for dialysis days. A root cause analysis for R12 determined that the nurse failed to accurately document medication administration. The DON/designee will educate license nursing on changing medication times to accommodate dialysis schedules. UM/Supervisors will review medication administration alerts every shift to identify missed medications prior to shift ending to ensure interventions have been initiated. D. DON/designee will conduct an audit by running the Medication Admin Audit report to assess for Missed medications weekly x 4 weeks until 100% compliance is achieved then every 2 weeks x 1 monthly until 100% compliance is achieved, then monthly x 4 months until 100% compliance is achieved. Results will be brought to the monthly QAPI meeting for review and further recommendations.	

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{F 684}	Continued From page 12 Manager) stated, "The medication was not given because R18 was at dialysis". 2/22/23 1:30 PM - Findings were reviewed during the exit conference with E1 (NHA), E16 (VPO) and E21 (DON).	{F 684}	E. Date of completion: 1/29/2024	
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's	F 690		1/29/24

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F 690	Continued From page 13 comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that for one (R8) resident out of two residents reviewed for bowel and bladder, the facility failed to ensure that a resident who enters the facility with an indwelling urinary catheter received an assessment to remove the catheter. Findings include: R8's clinical record revealed: 11/23/23 - R8 was readmitted to the facility after being hospitalized. A nursing readmission collection tool documented that R8 had an indwelling urinary catheter in place. The following physician orders were written on 11/23/23: -A physician order was written by E5 (MD) for a foley catheter. The order did not specify the reason for the catheter. -A physician order was written by E5 for R8 to be admitted to hospice. 11/24/23 - Review of an encounter note written by E17 (NP) revealed that R8 had the urinary catheter in place for comfort as the resident is on hospice. 12/20/23 - A review of R8's care plan revealed that R8 had a urinary catheter related to urinary retention.	F 690	F 690 A. R8 Foley Catheter was discontinued. B. All residents with foley catheters have the potential to be affected by this practice. DON/designee will review all residents with foley catheters to ensure there is an appropriate diagnosis along with foley catheter size. C. A root cause analysis was conducted, and it was determined that the licensed nurse failed to obtain a diagnosis and catheter size on admission. The Interdisciplinary Team will review all new admission foley catheter orders for appropriate diagnosis and catheter size or plan for removal. DON/designee will educate licensed nurses on the requirements of an appropriate diagnosis and size of foley catheters when the resident is admitted or order a foley catheter to be discontinued if not warranted. D. DON/designee will audit 100% or up to 5 residents with foley catheter orders for appropriate diagnosis and size weekly x 4 weeks until substantial compliance, every 2 weeks x 1 month until substantial compliance, then monthly x 4 months until substantial compliance. Results will be brought to the monthly QAPI meeting for review and further recommendations.	

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F 690	Continued From page 14 12/21/23 11:30 AM - An observation of R8 revealed that the indwelling catheter was in place. R8 was alert and oriented to her surroundings, and she was sitting up in bed. 12/21/23 12:15 PM - During an interview E13 (LPN) confirmed that R8 had a foley catheter since 11/23/23 and that the order for the catheter did not specify a reason for the catheter. E13 confirmed that the R8's indwelling catheter had not been assessed for its removal. 12/22/23 - A physician's order was written by E5 to discontinue the urinary catheter. 12/22/23 1:30 PM - Findings were reviewed with E1 (NHA), E16 (VPO) and E21 (DON).	F 690	E. Date of completion: 1/29/2024	
{F 695} SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations and interview, it was determined that for two (R36 and R37) out of four residents reviewed for respiratory care, the facility failed to ensure that each resident's oxygen concentrator filter was clean. Findings include: 12/13/23 at 11:55 AM - Observation of R36 and	{F 695}	F695- Respiratory/Tracheostomy Care and Suctioning A. R36 and R37 still reside at the facility. Their oxygen concentrator filters were cleaned immediately. B. All residents receiving oxygen therapy using oxygen concentrators can be	1/29/24

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{F 695}	Continued From page 15 R37's oxygen concentrators, located in the room they shared, revealed that the filters were dirty. 12/13/23 at 3:39 PM - During a second observation and interview, the finding was confirmed with E13 (LPN/UM). E13 immediately removed both filters to clean them. E13 stated that she would ensure the residents with oxygen concentrators would have the filters routinely cleaned. 12/22/23 at 2:15 PM - Finding was reviewed during the exit conference with E1 (NHA), E21 (DON) and E16 (VPO).	{F 695}	affected by this deficiency practice. DON/designee will audit all residents receiving oxygen therapy to ensure that oxygen concentrator filters are clean. All dirty oxygen filters will be cleaned immediately. C. Root cause analysis completed results identified there was not a process in place to alert staff members to clean the oxygen concentrator filters. New orders to clean oxygen concentrator filters weekly were added to resident ETAR. The nurse assigned to the resident will check and clean the oxygen concentrator filter weekly. DON/UM/Supervisor will educate licensed nursing staff on checking and cleaning the oxygen concentrator filters weekly on the assigned day. D. DON/UM/Supervisor will audit all residents who receive oxygen to verify their oxygen concentrator filters are clean weekly X 4 weeks until 100% compliance, 5 every 2 weeks X 1 month until 100% compliance, 5 monthly X 4 months until 100% compliance. 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: 1/29/2024	
{F 698} SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis.	{F 698}		1/29/24

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{F 698}	Continued From page 16 The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, it was determined that for two (R18 and R22) out of three residents sampled for dialysis care, the facility failed to ensure that R18's dialysis vascular access (fistula) was monitored, and R22's fluid restrictions orders from the dialysis center were implemented at the facility. Findings include: 1. Review of R18's clinical record revealed: 8/22/23 - R18 was admitted to the facility with diagnoses including end stage renal disease (ESRD) and dependance on renal dialysis (a process to remove toxins from the blood when the kidneys have failed). R18 received dialysis three times a week. 8/22/23 - R18's care plans documented, " ...At risk for complications due to requiring hemodialysis, dialysis vascular access (fistula) on left arm, check for presence of bruit and thrill (a vibration caused by blood flowing through the fistula to indicate proper function)...., every shift, administer mediations as ordered." 12/1/23 - 12/15/23 - A review of R18's EMAR also failed to show evidence that the dialysis vascular access was monitored for bruit and thrill every shift. 12/22/23 2:00 PM - Findings were confirmed with	{F 698}	F698- Dialysis A. 1. R18 still resides at the facility. Orders were updated to reflect assessment of dialysis vascular access site for bruit and thrill every shift. 2. R22 still resides at the facility. A fluid restriction order has been entered into the medical record and the care plan indicates fluid restriction. B. 1. All residents with dialysis vascular access have the potential to be affected. The DON/unit manager will audit all residents with dialysis vascular access to ensure there is an order for monitoring bruit and thrill every shift. 2. All residents on dialysis and/or with a fluid restriction have the potential to be affected. DON/Dietitian will audit all residents who receive dialysis to determine if fluid restriction is ordered and ensure it is care planned. If it is not ordered, the provider will be notified to determine if a fluid restriction is needed. C. 1. Root cause analysis was completed, results identified that the facility failed to utilize the batch entry order feature for Hemodialysis resulting in an order to monitor dialysis vascular access not being entered. The staff developer will educate	

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{F 698}	Continued From page 17 E1 (NHA). 2. Review of R22's clinical record revealed: 3/28/23 - R22 was admitted to the facility with diagnoses including End Stage Renal Disease (ESRD). R22's orders included dialysis treatment three times a week on Tuesday, Thursday, and Saturday. 3/28/23 - R22's care plans included, "...Observe for signs and symptoms of complications related to ESRD including fluid overload...". 11/2/23 - A review of E7's (dietitian) documentation recorded a fluid goal of 1,600 ml - 1,900 ml of fluids every 24 hours. 12/15/23 - A review of R22's EMR failed to reveal evidence of an order for fluid restrictions. 12/19/23 11:15 AM - During a telephone interview E23 (dialysis nurse manager) stated, "This information was emailed to E7 (Dietitian) on 7/31/23. E22 orders are for 1,000 ml fluid restriction every 24 hours." 12/19/23 12:30 PM - Findings were confirmed with E1 (NHA), E7 (Dietitian), and E13 (LPN Unit Manager).	{F 698}	licensed nurses on utilizing batch entries for Hemodialysis to ensure orders for dialysis vascular access and documentation of that monitoring is entered in the orders. 2. Root cause analysis completed results identified the facility did not have a process to follow up with dialysis center when a dialysis resident did not have a fluid restriction ordered. The dietitian will reach out to the dialysis center, if a dialysis resident does not have a fluid restriction ordered he/she will get clarification if fluid restriction order is necessary. Dietitian will be educated on revised workflow for ascertaining fluid restrictions. Any communication regarding a change in resident□s plan of care between the dietician and dialysis center will be documented in the dietician progress note. D. 1.DON/designee will audit residents with dialysis vascular access to verify monitoring orders are in chart and documented appropriately weekly X 4 weeks until substantial compliance, every 2 weeks X 1 month until substantial compliance, then monthly X 4 months until substantial compliance. 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. Dietitian will audit 100% of residents on fluid restriction to ensure it is ordered and	

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{F 698}	Continued From page 18	{F 698}	care planned weekly X 4 weeks until 100% compliance, every 2 weeks X 1 month until 100% compliance, then monthly X 4 months until 100% compliance. 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: 1/29/2024	
{F 730} SS=D	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 two (E28 and E29) out of three sampled employees. Findings include: Review of the latest CNA performance appraisals revealed the following performance review dates and performance review due dates: E28: No performance review present for a 4/10/23 performance due date.	{F 730}	F730- Performance Reviews A. No residents were affected by the deficient practice. B. All Nursing Aides have the potential to be affected by this deficient practice. E28 and E29 have received performance evaluations. A compliance audit by the new HR Director/Designee will be conducted to ensure all performance reviews are completed and signed within the required time frame. C. A root cause analysis identified that when the HR Director resigned, the facility	1/29/24

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{F 730}	Continued From page 19 E29: No performance review present for a 9/1/23 performance due date. The following interviews were obtained on 12/15/23: -1:30 PM: E31 confirmed the lack of documentation for the above performance reviews. -4:30 PM: E1 confirmed the lack of documentation for the above performance reviews. Review of the plan of correction for the 9/25/23 survey with a completion date of 11/30/23 revealed the following: "B. 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 the NHA being responsible to ensure completion... ." 12/22/23 1:30 PM - Findings were reviewed with E1 (NHA), E16 (VPO) and E21 (DON).	{F 730}	failed to ensure all performance evaluations were completed in a timely manner. The NHA/Designee will provide additional education to the new HR Director. The HR director/designee will generate a monthly report using the Viventium Employee portal for a hire date roster. This will be pulled to reflect evaluations due the following month. This roster will then be used to audit performance evaluations when they are completed. D. The Human Resources Director/Administrator will audit up to 5 Nurse aides with upcoming performance reviews due monthly x 4 months until 90% compliance. All audits will be submitted to the QAA committee monthly. The results of the audits will be reported in x4 months. The QAA committee will determine what, if any, additional intervention is needed at the end of the 4 months. E. Date of completion: 1/29/2024	
{F 756} SS=D	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	{F 756}		1/29/24

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{F 756}	Continued From page 20 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 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 for three (R3, R20, and R22) out of three residents sampled for monthly drug regimen review by a licensed pharmacist, the facility failed to provide evidence that the monthly medication review was completed for November 2023. Findings include: 8/20/20 - A facility policy titled, "Medication	{F 756}	F756- Drug Regimen Review A. R3, R20 and R22 still reside at the facility and were reviewed by the consultant pharmacist in November and had no recommendations for the month. B. All residents have the potential to be affected by this deficient practice. An audit will be conducted of census vs drug regimen review for December. All	

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{F 756}	Continued From page 21 Regimen Review", documented, " ...The consultant pharmacist performs a compressive review of each resident's medications at least monthly ..." 1. 1/25/22 - R3 was admitted to the facility. 10/31/23 - R3's monthly medication review was completed by the consultant pharmacist. 12/15/23 12:15 PM - A review of R3's medical records failed to show evidence of a review for 11/2023. 2. 3/22/23 - R20 was admitted to the facility. 10/31/23 - R20's monthly medication review was completed by the consultant pharmacist. 12/15/23 12:15 PM - A review of R20's medical records failed to show evidence of a review for 11/2023. 3. 3/28/23 - R22 was admitted to the facility. 10/31/23 - R22's monthly medication review was completed by the consultant pharmacist. 12/15/23 12:15 PM - A review of R22's medical records failed to show evidence of a review for 11/2023. 12/15/23 1:15 PM - During a phone interview with E35 (consultant pharmacist) stated, "I had Internet issues, and I could not complete the reviews". 12/15/23 2:30 PM - Findings were confirmed with E1 (NHA).	{F 756}	November DRRs have been reviewed and signed and are being uploaded in the EMR. C. Root cause analysis completed and found that the pharmacist consultant failed to complete The Consultant Pharmacist Drug Regiment Review assessment in Point Click Care for residents seen that did not need recommendations. The consultant pharmacist will be educated on completing Consultant Pharmacist Drug Regiment Review assessment in Point Click Care. R2, R20, and R22 were reviewed by the consultant pharmacist in November and had no recommendations. The Medical records coordinator will be educated on uploading all drug regiment reviews into miscellaneous tab of EMR for those residents who have recommendations. D. The DON/designee will audit the consultant pharmacy monthly recommendations to verify they are maintained and readily available monthly X 4 months until 100% compliance. 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: 1/29/2024	

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{F 756}	Continued From page 22 12/22/23 2:15 PM - Findings were reviewed with E1, E21 (DON), and E16 (Corporate VPO) at the exit conference.	{F 756}		
{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 be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that for one (Fenwick Unit) out of three units sampled for medication storage, the facility failed to ensure the temperature of the	{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	1/29/24

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{F 761}	Continued From page 23 refrigerator was maintained at an acceptable level. Findings include: 12/11/23 11:15 AM - Review of the temperature log on the medication storage refrigerator documented temperatures between minus ten degrees and minus twenty degrees Fahrenheit from 12/1/23 though 12/11/23 for a total of 11 days. The inside temperature of a refrigerator in which medications are stored should range between thirty-six to forty-six degrees Fahrenheit (Centers for Disease Control 2023). 12/11/23 11:30 AM - Finding were confirmed with E13 (LPN UM).	{F 761}	affected by this deficient practice. All medication refrigerators' temperatures were checked and verified to be within the allowable temperature range. C. Root cause analysis was conducted, it determined that the facility staff were not directly assigned to assess the daily temperature monitoring for medication. The 3-11 Nurse Supervisor will be responsible for ensuring the daily temperature log is completed and the temperature is appropriate. The DON/Designee will provide in-service to licensed nurses on medication storage policy including monitoring medication refrigerator temperatures daily and ensuring the temperature is within the acceptable temperature range. D. The DON/Designee will audit all medication room refrigerators for daily temperature checks and appropriate temperature range weekly x 4 weeks until 100% compliance, then every 2 weeks x 1 month until 100% compliance, and then monthly x 4 until 100% compliance. 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: 1/29/2024	
{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-	{F 804}		1/29/24

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{F 804}	Continued From page 24 §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, and a test tray result, it was determined that the facility failed to provide food that was served at an appetizing temperature and that was palatable. Findings include: 12/13/23 9:25 AM - Observation on the Linden Unit, R11's breakfast tray was delivered. The following interviews were obtained on 12/13/23: 10:00 AM - During an interview, R11 stated that her food is consistently unpleasant, both in taste and temperature. Additionally, R11's stated that her room is at the end of a hallway and her hallway is the last hallway to be served at each meal. Today, breakfast was delivered at 9:25 AM and it consisted of scrambled eggs/sausage on a bun toast, which was inconsistent with the menu as ham was supposed to be on the breakfast sandwich. R11 stated that she does not eat sausage. 11:50 AM - During an interview, E6 (Dietary Director) stated that sausage was served at breakfast today instead of ham because the ham was frozen and could not be served for breakfast. E6 stated this food change was the result of a communication breakdown between the kitchen	{F 804}	F804- Food Palatability A. R11 food preferences were reviewed by the dietician and updated as indicated. B. All residents have the potential to be affected by the deficient practice. The facility will complete the initial tray service evaluation tool to monitor temperatures throughout the tray line process including a hold tray. C. A root cause analysis identified the facility Dietary Director did not follow the protocol for making menu changes/notification to residents. If there is a menu change, all posted Menus will be updated to ensure they are accurate. The Administrator will educate the Dietary Director on ensuring all scheduled meals are prepped accordingly so the residents receive what is on the scheduled menu. The Regional Dietician/designee will educate the Food Service Director on ensuring meals are appetizing to residents, palatable, and served at appropriate temperatures for residents to enjoy. The food service director/dietitian will conduct test tray temperature checks for holding temps for last tray served on the designated unit 3 times a week. The Regional Director/designee will complete the tray service evaluation tool weekly for	

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{F 804}	Continued From page 25 staff. 12/19/23 12:15 PM - A test tray was sampled from the Linden unit. The test tray consisted of chicken tenders, french fries, an oatmeal cookie and a can of soda. The chicken tenders and the french fry temperature were taken by E6 and they were 138 degrees Fahrenheit and 117 degrees Fahrenheit respectively. The chicken tenders and the fries were not crispy and lacked flavor. When questioned about the lack of crispiness of the chicken tenders and fries, E6 stated that the food would be overcooked if it was crispy when it was delivered to the residents. 2/22/23 1:30 PM - Findings were reviewed during the exit conference with E1 (NHA), E16 (VPO) and E21 (DON).	{F 804}	4 weeks. Department heads will perform daily rounds (Angel Rounds) to include interviews with residents to include meal palatability satisfaction. D. A member of the administration will sample one test tray daily prior to meal service to ensure the meal is palatable and at an appetizing temperature with feedback provided weekly x 4 weeks until 100% compliance, then every 2 weeks x 1 month until 100% compliance, then monthly x 2 months until 100% compliance. 5 residents will be interviewed weekly x 4 weeks until substantial compliance, then every 2 weeks x 1 month until 100% compliance, then monthly x 2 months until 100% compliance. 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: 1/29/2024	
{F 842} SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.	{F 842}		1/29/24

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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 842}	Continued From page 26 §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 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	{F 842}		

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{F 842}	Continued From page 27 (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for six (R24, R2, R18, R35, R6 and R7) out of thirty-five residents reviewed for resident records, the facility failed to ensure that the resident records were complete, accurate and readily accesible. Findings include: 1. R24's clinical record revealed: 12/13/23 - During review of R24's electronic medical record, the record lacked evidence of the 4/28/23 and 10/23/23 notes written by E22 (Psychiatrist). The Surveyor requested E22's notes. 12/13/23 at 2:00 PM - During an interview with E1 (NHA), finding was reviewed and confirmed after receiving hard copies of these notes. The facility failed to ensure that R24's electronic medical record was complete and readily accessible. 2. R2's clinical record revealed:	{F 842}	F842- Resident Records A. 1. R2 still resides at the facility and had no adverse effects from the deficient practice. Medication for R2 was held as ordered but documented as being held in the EMR progress notes instead of EMAR. Documentation best practice was reviewed with the nurse. 2. R6 still resides at the facility and had a new fall risk scoring tool assessment accurately completed. Interventions reviewed based on accurate assessment to determine if they were appropriate or if any changes needed to be completed. 3. R7 still resides at the facility and had a new fall risk scoring tool assessment accurately completed. Interventions reviewed based on accurate assessment to determine if they were appropriate or if any changes needed to be completed. 4. R18 still resides at the facility and the	

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{F 842}	Continued From page 28 6/29/23 - R2 was admitted to the facility with multiple diagnoses, including congestive heart failure. 7/6/23 - A physician's order was written for metoprolol 50 mg by mouth two times a day for high blood pressure, hold the medication for a systolic blood pressure below 110. 12/11/23- A review of R2's December 2023 medication treatment administration (MAR) record revealed that on 12/2/23 R2 received metoprolol at 4:00 PM; R2's systolic blood pressure reading was documented as 104. 12/19/23 11:00 AM - During an interview, E30 confirmed that the MAR did have metoprolol checked off as being administered to R2 at 4:00 PM, and that R2's systolic blood pressure reading was documented as 104. E30 further stated that the metoprolol was not given to R2 at 4:00 PM, as was revealed by the review of a nursing note in another section of the electronic medical record (EMR) written on 12/2/23. 3. R18's clinical record revealed: 8/22/23 - R18 was admitted to the facility with multiple diagnoses, including end stage renal disease. 11/24/23 - A physician's order was written that R18's medications may be crushed and administered together at one time related to "SPECIFY". 12/19/23 11:10 AM - During an interview, E30 confirmed that the physician's order to crush	{F 842}	order was updated to reflect the reason medications needed to be crushed. 5. R24 still resides at the facility and any missing providers notes were uploaded to the EMR. 6. R35 no longer resides at the facility. B. 1. (R2). All residents have the potential to be affected by this deficient practice. DON/Designee will audit the past 24 hours of blood pressure medication with parameters to determine if it was given/held per the parameters and verify the documentation on the MAR matches actual administration. For any inaccuracies, providers will be notified. 2. (R6 &7). All residents have the potential to be affected by this deficient practice. The DON/designee will audit the last 7 days of falls to ensure a post fall risk assessment was both completed and accurate. Any not done will be completed. The DON/designee will audit the last 7 days of fall risk scoring tool assessments completed to verify they were completed accurately. Any assessment found to be inaccurate will be reassessed and a new assessment completed. Fall Risk assessments will be reviewed during morning meetings for completion and accuracy for all new admissions and residents with falls. 3. (R18) The order listing report will be run to review all resident orders with crushed medications and changes/corrections made if indicated. 4. (R24) All residents who are seen by the psychiatrist have the potential to be	

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{F 842}	Continued From page 29 medications did not include a reason why the medications would be crushed and given together to R18. E30 confirmed that the order to crush the medications should state the reason to crush the medications. 4. R35's clinical record revealed: 9/29/23 - R35 was admitted to the facility with multiple diagnoses including a fractured pelvis from a recent fall. A Fall Assessment Risk Scoring Tool was completed which documented R35 as a 7 on the fall risk scale. According to the Fall Assessment Risk Scoring, a fall risk score under 9 is considered a low fall risk. 12/14/23 - A review of the Fall Assessment Risk Scoring revealed that the following sections were not accurately documented: A1. History of falls: No falls or fractures was selected. R35 had a recent fall prior to her admission; the selection would have added 2 points to R35's total fall score. F1 Predisposing Diseases: Previous fractures was not selected; R35 had a previous fracture prior to her facility admission; the selection would have added 2 points to R35's total fall score. F2 Medications: The total medication amount taken in the last 7 days did not contain a selection checked. R35's hospital discharge records indicated that R35 had received a diuretic in the last 7 days, the selection would have added 2 points to R35's total fall score. F3 Medications: Was there a change in medications the last 7 days? R35's hospital	{F 842}	affected. Medical record/designee will audit the psychiatrist□s last visit schedule and verify all patients visited by the Psychiatrist, have their progress notes entered in EMR. 5. (R35) All residents with a change in condition have the potential to be affected. DON/unit manager will audit the last 14 days of change in conditions to verify emergency contact or responsible party were notified of change in condition. If they were not notified, notification will be made by the DON or Unit manager C. 1. (R2) Root cause analysis completed and resulted that the nurse mistakenly documented that the medication was given in the MAR and documented in the progress notes that it was held due to blood pressure parameters. The nurse will be educated on how to correct mistaken documentation. 2. (R6&7) Root cause analysis completed, and results identified that the licensed nurse did not complete the assessment after a fall. Licensed staff did not demonstrate competency in completing the assessment. The Fall Risk Assessment is to be completed after each fall, admission, readmission and quarterly. The staff development coordinator/designee will educate licensed nursing on the Fall risk assessment requirements and the fall assessment tool (including ensuring it is completed accurately). 3. (R18) Root cause analysis completed, and it was determined that the order to crush medications was put in EHR	

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{F 842}	Continued From page 30 discharge records documented that R35's medications contained changes upon discharge; the selection would add 1 point to R35's total fall score. 11/30/23 - A progress note written in the electronic medical record (Emr) revealed that R35 fell in her room and hit her head during the fall. 12/15/23 - 1:15 PM - During an interview E12 (RN UM) confirmed that R35's admission fall assessment score of 7 was not accurate to reflect R35's actual fall risk at the time of her admission. 5. 8/21/23 - R6 was admitted to the facility with diagnoses including acute osteomyelitis (infection of the bone) of the right ankle and foot, and left femur (thigh bone) fracture. 11/28/23 4:00 AM - R6's post fall assessment documented a score of twelve (high risk). 12/10/23 3:10 PM - R6's post fall assessment documented a score of eight (low risk). The assessment failed to include R6's use of antipsychotics (Haldol) and antidepressant (trazadone). 12/10/23 3:30 PM - Findings were confirmed with E12 (LPN Unit Manager). 6. 10/12/23 - R7 was admitted to the facility with diagnoses including falls, and a stroke affecting his right dominant side. 11/30/23 1:29 PM - R7 was sent to the hospital for unwitnessed fall.	{F 842}	incompletely. The nursing leadership will run the order listing report to ensure the orders are entered completely (including any individualized specifications). The staff development coordinator/designee will educate licensed nurses on ensuring orders requiring individualized specifications are completed and accurate. 4. (R24) It was determined that the root cause was lack of a process to ensure timely receipt and upload psychiatrist visit notes into the medical chart. The Psychiatrist will be documenting his notes in Point Click Care moving forward. The SDC/designee will in-service medical records staff on verifying psychiatrist visit documentation into the medical record timely. 5. (R35) A root cause analysis identified the staff misunderstood the requirements to call family when the resident is their own responsible party. When a resident has a change in condition, the nurse assigned to them is responsible for notifying the emergency contact and/or responsible party. The unit manager and/or charge nurse is to verify that contact has been made prior to the end of the shift when the change of condition occurred. Resident change in condition RP notification will be confirmed during clinical meeting daily. The staff developer will educate licensed nurses on notification of emergency contact and/or responsible party after a change in condition. D.	

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{F 842}	Continued From page 31 12/19/23 2:15 PM - A review of R7's nursing progress notes failed to show evidence that a post fall assessment was completed for the fall on 11/30/23 at 1:29 PM. 12/19/23 - 3:15 PM - Findings were confirmed with E1 (NHA). 12/22/23 1:30 PM - Findings were reviewed at the exit conference with E1 (NHA), E16 (VPO) and E21 (DON)	{F 842}	1. (R2) The DON/designee will audit 10 residents with hold parameters to verify medication was give/held appropriately and documented accurate in EMAR 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. 2. (R6 &7) The DON/designee will audit Fall risk assessments to ensure they are completed and are accurately done 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. The DON/designee will audit all 10 new admissions fall risk assessment tool to verify they are completed accurately weekly x 4 weeks until 100% compliance, then every 2 weeks x 1 month until substantial 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. 3. (R18) The DON/designee will audit the order listing report at the morning meeting to verify any order requiring individualized specifications are entered completely weekly x 4 weeks until 100% compliance, then every 2 weeks x 1 month until 100% compliance and then monthly x 4 months	

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{F 842}	Continued From page 32	{F 842}	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. 4. (R24) The DON/designee will audit psychiatrist visit schedule to verify provider notes are medical chart after visit 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 5. (R35) The DON/Unit manager will audit 100% or up to 10 residents with change of condition to ensure notification was made to responsible party and/or emergency contact weekly x 4 weeks until substantial compliance, then every 2 weeks x 1 month until 100% compliance, then monthly x 4 months until 100% compliance. 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: 1/29/2024	

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{F 849}	Continued From page 33	{F 849}		
{F 849} SS=D	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. §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	{F 849}		1/29/24

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{F 849}	Continued From page 34	{F 849}		

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 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

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{F 849}	Continued From page 35 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 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	{F 849}		

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{F 849}	Continued From page 36 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. (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	{F 849}		

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{F 849}	Continued From page 37 practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility records and interviews, it was determined that for one (R26) out of three residents reviewed for hospice, the facility failed to ensure that hospice records were present. Findings include: 8/10/23 - R26 was admitted to the facility. 12/1/23 - R26 started with hospice care. 12/19/23 1:00 PM - An observation revealed that R26 did not have a hospice binder developed and present at the nursing unit according to the facility's 9/25/23 plan of correction, with a completion date of 11/30/23. The following interviews were obtained on 12/21/23: 10:45 AM - E13 (LPN, UM) confirmed that R26 did not have a hospice binder at the nursing station. 1:00 PM - E11 (SW) confirmed that R26 did not have a hospice binder at the nursing station. 12/22/23 1:30 PM - Findings were reviewed at the exit conference with E1 (NHA), E16 (VPO) and E21 (DON)	{F 849}	F849- Hospice Services A. R26 still resides at the facility. Social services contacted Hospice and a hospice binder was placed on the unit at the time of survey. 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 binder is on the unit. C. Root cause analysis identified inconsistent use and updating of hospice binders. A hospice binder order has been developed to facilitate review and use of binder to facilitate communication between hospice and facility staff. Hospice staff were educated by Social Services on the use/sections of the binder. DON/designee will educate social services that when a resident signs on with hospice services, the hospice binder is to be started at signing, include all pertinent hospice documentation and be placed on the unit. Two prepared hospice binders are available in social services for immediate use, should a resident be signed into hospice. D. DON/designee will audit residents on hospice services to ensure hospice binder is complete and is on the units weekly X 4 weeks until 100% compliance, then every 2 weeks X 1 month until 100% compliance, then monthly X 4 months until 100% compliance. All audits will be submitted to the QAA committee monthly.	

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 _____	R-C 12/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 849}	Continued From page 38	{F 849}	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: 1/29/2024	