STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085032	A. BUILDING _____ B. WING _____	C 09/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMINSTER VILLAGE HEALTH	1175 MCKEE ROAD DOVER, DE 19904

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F 000	INITIAL COMMENTS An unannounced complaint survey was conducted at this facility from September 11, 2016 through September 22, 2016. The deficiencies cited in this report are based on record reviews, staff interviews, other interviews, and review of other facility documentation as indicated. The census the first day of the survey was 58. The sample size included two (2) active and two (2) closed records. Abbreviations and definitions used in this report are as follows: DON - Director of Nursing; ADON - Assistant Director of Nursing; NHA- Nursing Home Administrator / Executive Director; AED- Assistant Executive Director; CNA- Certified Nurse Aide; LPN- Licensed Practical Nurse; RN- Registered Nurse; SW- Social Worker; Narcotic- a strong pain medication used to treat significant pain; Medication Administration Record (MAR)- the record of medications given to residents by nursing home staff; ROM - Range of Motion- exercises provided with the assistance of trained staff to maintain mobility and prevent stiffening; Tracheostomy- a surgically made opening in the neck in which a tube is placed for breathing; Ambu-bag- a respiration device with a squeezable bag / bulb and mask that is placed over the airway to provide artificial breathing in emergencies; Full code- a status where cardiopulmonary resuscitation will be performed in the event that a	F 000		

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

Electronically Signed | 10/20/2016

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F 000	Continued From page 1 person's heart stops beating or they stop breathing; AHA- American Heart Association- an organization that sets standards and provides education on heart related diseases and conditions; Cardiopulmonary resuscitation (CPR)- a process during which chest compressions and artificial breathing are provided to a person who has no pulse or respirations; EMT- Emergency Medical Technician / basic life support provider, responds to 911 calls; ALS- Paramedic / advanced life support provider, responds to 911 calls; Ventilations- breaths provided to a non-breathing person through artificial means such as use of an Ambu-bag; Foreskin-a layer of smooth muscle tissue and skin that covers the tip of the penis in uncircumcised males; Uncircumcised- the foreskin of the penis has not been removed; Phimosis- a condition where the foreskin tightens and cannot be pulled back; urologist- a medical doctor specializing in diseases and conditions of the urinary tract; Basic Life support (BLS)- Basic emergency care provided to a person who has had cardiac or respiratory arrest or other medical emergency; Advanced Life support (ALS)- A higher level of emergency medical care usually provided by Paramedics; Pain Scale 0 - 10- A way of rating pain commonly used in the healthcare system where "0" means no pain, "1" means very little pain and "10" being severe pain; Oxygen saturation-amount of oxygen in the blood; Chest compressions-act of applying pressure to someone's chest in order to help blood flow	F 000		

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F 000	Continued From page 2 through the heart; Patency-open, unobstructed; Anoxic-abnormally low amount of oxygen in the body tissues; Oxygen-air the stuff we breathe, the thing that makes life possible; Hypoxic-condition when the body is deprived of oxygen; Ventilations-the exchange of air between the lungs and the atmosphere so that oxygen can be supplied.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or	F 157		11/8/16

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F 157	Continued From page 3 regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and physician interview, it was determined that for one resident reviewed (R1) out of four (4) sampled residents, the facility failed to consult with the resident's physician when there was a need to alter the resident's treatment significantly to ensure effective pain control. The staff failed to consult with the physician to discuss the resident's "as needed" narcotic pain medication which was being used with increasing frequency but with less effectiveness reported by the resident. Findings include: Cross-refer F309. Review of the clinical record for R1 and facility documents revealed: R1 had an order in effect from the date of admission (9/2/16) for a narcotic pain medication to be given every 6 hours as needed with one (1) tablet for moderate pain (identified in the order as a self-rated score of 5 - 7 on a scale of 0 -10) or two (2) tablets for severe pain (identified in the order as a self-rated score of greater than 7 on a scale of 0 - 10). R1 had multiple sources of pain including a history of back pain and back surgery, recent throat cancer diagnosis, and recent surgical procedures. According to the electronic	F 157	F157 cross-refer F309 A. R1 was discharged on 9/7/16 from the facility. B. An audit was completed by the R.N. Supervisor, which revealed that no other residents were affected. C. The EMR has been changed to reflect frequency and doses of previously administered pain medications under the comment tab. Nursing staff have been educated by Staff Development Coordinator/Designee on: a.Checking the comment tab in the EMR for frequency and doses of previously administered pain medications, prior to administering the next dose. b.Calling the physician for changes in pain management in the event that the resident□s pain is not managed with the current physician orders. D. R.N. Supervisor/Designee will monitor PRN effectiveness report daily and intervene as needed. Variances will be monitored and trended monthly in QAPI meetings for continued compliance.	

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F 157	Continued From page 4 Medication Administration Record (MAR), R1 was given doses of pain medication less than 6 hours apart which was more frequent than the order allowed. No physician consultation regarding R1's pain, ineffective pain control, or need for more frequent doses of pain medication was found in the clinical record. On 9/19/16 at 3 PM, E8 (physician) stated to the surveyor that R1 had been taking narcotic pain medication prior to admission to the facility and that he was never consulted by the facility staff to discuss R1's pain management, ineffective pain control, or the need for a change in the frequency of pain medication. These findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON), and E4 (AED) at the exit conference on 9/22/16 at 11:45 AM.	F 157		
F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility grievance documentation, and staff interview, it was determined that for one (1) resident reviewed (R3) out of four (4) sampled residents, the facility failed to have evidence of prompt efforts to resolve grievances related to resident care and treatment. There was no evidence found that the facility staff followed-up on grievances reported on behalf of R3 to ensure that corrective actions	F 166	F166 cross-refer F250 A. R3 grievances and concerns have been addressed by the AED with R3 family who were receptive of the resolutions on 9/27/16. B. All other residents had the potential to be affected. An audit of current grievances has been completed by the	11/8/16

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F 166	Continued From page 5 were effective. Consequently, repeat grievances were reported. Findings include: Cross-refer F250. Review of the clinical record for R3 and facility documents revealed: According to the facility's "Grievance, Complaints and Suggestions" policy / procedure, the facility's social worker shall act as an advocate for residents and / or their responsible parties who require assistance with the (grievance) process; the resident and / or their responsible party will be kept informed of the process taking place to resolve the grievance; and resolution of the reported concern is desired within three (3) to five (5) working days from the date the complaint was filed. A care plan meeting summary note for R3 written by E5 (SW) on 2/11/16 timed 2:20 pm indicated that E6 (daughter of R3) requested that the rehabilitation staff train and educate the nursing staff on R3's range of motion exercises. It was documented that a nursing supervisor (unidentified in the note) would keep in contact with E6 to provide updates. It was also documented in this note that staff should put R3's wet t-shirts in plastic bags. E5 wrote a note dated 4/13/16 timed 3:50 pm that she (E5) had called E6 to address grievances which were not identified in the note. A grievance form dated 5/14/16 indicated that E6 complained of on-going issues with staff placing wet t-shirts in the laundry bag for family to take home without first placing the wet shirts in plastic	F 166	AED, and there are no outstanding concerns. The Social Services Director is meeting with the residents/family members who had previously placed grievances to better understand resident choice and social services needs. The Social Services Director has reviewed and audited the current, provided social services to ensure resident needs are met. C. A single, secured location which is accessible by residents and visitors has been identified for grievances. Completed grievances will be retrieved on a daily basis by Social Services Director/Designee, reviewed and provided to the proper department for reconciliation within policy guidelines. The AED/Designee will educate the Social Services Director and department staff on this process. A CSWE certified Social Services Director was hired on 10/4/16, who will identify and plan to meet resident social services needs, and ensure effective communication with families and follow-up by facility staff to ensure the identified care issues / grievances were addressed and resolved. The Staff Development Coordinator/Designee will educate Social Services Director on this process. D. AED/Designee will review the timely resolution of grievances and social services documentation for completion on an on-going basis for compliance. Audit to be conducted weekly by the AED/designee until 100% compliance has been verified. Results will be monitored monthly in QAPI meetings for continued	

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F 166	Continued From page 6 bags. According to follow-up documentation on the form, staff was re-educated on this issue. A review of facility grievance forms provided to the surveyor by E6 during the survey revealed the following reported grievances: -6/25/16 A t-shirt wet with urine was not in a plastic bag as previously requested by R3's family and had been found by E6 in R3's laundry bag; -6/25/16 E6 reported a concern about R3's positioning in his wheelchair when she arrived to visit and wrote on the form that this was a repeat issue; and -6/26/16 E6 reported that she had to remind two CNAs that R3 needed ROM and then despite visual aids (photos and instructions) posted on the wall in R3's room, the CNAs were unsure of how to do the ROM. E-mail communication between E6 and facility staff regarding the above three grievances was reviewed by the surveyor and revealed that as of 7/27/16 the grievances had not been resolved due to the forms being lost and not going through the facility's established grievance resolution process. According to the email, the following day (7/28/16), E4 (AED) personally took over family communication and grievance resolution responsibilities for R3. E1 (NHA) advised the surveyor on 9/22/16 at approximately 11:15 AM that E5 had last worked in the facility on 6/13/16 and was no longer employed there. Consequently there was no Social Worker available when the 6/25/16 and 6/26/16 grievances were filed by E6. E1 also explained that some staffing changes in R3's primary CNA and in the day shift nursing supervisor likely contributed to ineffective	F 166	compliance.	

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F 166	Continued From page 7 follow-up and communication with E6 about grievance resolution. These findings were reviewed with E1, E2 (DON), E3 (ADON), and E4 (AED) at the exit conference on 9/22/16 at 11:45 AM.	F 166		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and review of other facility documentation as indicated, it was determined that the facility failed to provide medically-related social services to maintain the highest practicable well-being of one (1) resident reviewed (R3) out of four (4) sampled residents. There was a lack of evidence of identification of and planning to meet R3's social service needs, effective communication with R3's family, and effective follow-up by facility staff to ensure that identified care issues / grievances were addressed and resolved. Findings include: Cross-refer F166. Review of the clinical record for R3 and facility documents revealed: According to facility grievance forms completed by E6 (daughter of R3) on behalf of R3, multiple	F 250	F250 cross-refer F166 A. R3 grievances and concerns have been addressed by the AED with R3 family who were receptive of the resolutions on 9/27/16. B. All other residents had the potential to be affected. An audit of current grievances has been completed by the AED, and there are no outstanding concerns. The Social Services Director is meeting with the residents/family members who had previously placed grievances to better understand resident choice and social services needs. The Social Services Director has reviewed and audited the current, provided social services to ensure resident needs are met. C. A single, secured location which is	11/8/16

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F 250	Continued From page 8 concerns related to care and services were reported to the facility over a period of three months (March, 2016 through June, 2016). For this three month time frame, no evidence of active and effective involvement by E5 (SW) was found during clinical record review or provided to the surveyor upon request. There was no evidence found that R3's on-going social services needs, including effective family communication and grievance resolution, were identified and planned for. Interview with E1 (NHA) on 9/22/16 at 11:15 AM revealed that during this time frame, the facility was undergoing extensive renovations and R3's room was changed several times resulting in a change of caregivers. E1 also confirmed the lack of evidence of effective communication and intervention by E5 to address family concerns and ensure that efforts to resolve reported grievances were effective and maintained. These findings were reviewed with E1, E2 (DON), E3 (ADON), and E4 (AED) at the exit conference on 9/22/16 at 11:45 AM.	F 250	accessible by residents and visitors has been identified for grievances. Completed grievances will be retrieved on a daily basis by Social Services Director/Designee, reviewed and provided to the proper department for reconciliation within policy guidelines. The AED/Designee will educate the Social Services Director and department staff on this process. A CSWE certified Social Services Director was hired on 10/4/16, who will identify and plan to meet resident social services needs, and ensure effective communication with families and follow-up by facility staff to ensure the identified care issues / grievances were addressed and resolved. The Staff Development Coordinator/Designee will educate Social Services Director on this process. D. AED/Designee will review the timely resolution of grievances and social services documentation for completion on an on-going basis for compliance. Audit to be conducted weekly by the AED/designee until 100% compliance has been verified. Results will be monitored monthly in QAPI meetings for continued compliance.	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable	F 279		11/8/16

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F 279	Continued From page 9 objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe 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 §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined that for two (2) residents reviewed (R1 and R2) out of four (4) sampled residents, the care plan developed by the facility failed to include measurable objectives and timetables to meet nursing care needs as well as describe specific services to be furnished by staff to address care needs. R1 had a tracheostomy for breathing but the care plan failed to include a goal related to maintaining patency (opening) and failed to identify services to be furnished if an emergency occurred. R2 was an uncircumsized male resident however, his care plan failed to include services to be furnished to address care and monitoring of the foreskin. Findings incude: 1. Cross refer F157 and F309. Review of facility documents and the clinical record for R1 revealed:	F 279	F279 cross-refer F157 and F309 A. Resident R1 was discharged from the facility on 9/7/16. Resident R2 was discharged from the facility on 8/31/16. B. All other residents had the potential of being affected. An audit has been completed by RNAC to determine if any other resident does not have measurable objectives and timetables to meet nursing care needs as well as describe specific services to be furnished by staff to address care needs. Residents identified have had their care plan reviewed and updated to include measurable objectives, timetables and specific services. C. The Corporate RNAC/Designee will educate the RNAC on completion of care plans to include measurable objectives and timetables to meet nursing care needs as well as describe specific	

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F 279	Continued From page 10 The care plan developed by the facility for R1, a resident with a tracheostomy, included the goal of having no infections. There was no goal related to maintaining patency (opening) or specific instructions for staff to follow in the event of an emergency. Interview with E7 (LPN) on 9/11/16 at 3:10 PM revealed that she (E7) was R1's primary nurse on the day shift and that an Ambu-bag was obtained prior to R1's arrival in the facility for admission on 9/2/16 and remained available at her bedside during her stay in the facility. This information, however, was not included in the tracheostomy care plan developed by the facility. 2. Review of facility documents and the clinical record for R2 revealed: R2 was an uncircumsized male resident of the facility. A urologist consultation dated 4/20/16 indicated that R2 had developed phimosis requiring a corrective procedure (cutting of a small slit) performed by the urologist who wrote a specific instruction for staff not to retract (pull back) the foreskin. A urologist consultation report dated 4/26/16 documented resolution of this problem. The care plan for R2, however, contained no reference to or documentation of the specific instruction for staff not to retract the foreskin. A medical note dated 7/28/16 revealed that R2 required the same corrective procedure to be performed and the instruction not to retract the foreskin was again documented. When asked on 9/19/16 at 12:05 PM where in the care plan this specific instruction was communicated to facility staff, E2 (DON) provided a copy of a Special Instructions section that is viewable to staff using the facility's computerized charting system. The instruction to not retract the foreskin was present but there was no way to determine	F 279	services to be furnished by staff to address care needs. D. The Corporate RNAC/Designee will audit the completion of care plans weekly until 100% compliance is achieved. Variances will be monitored and trended monthly in QAPI meetings for continued compliance.	

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F 279	Continued From page 11 the date it was added. The only dated care plan instruction related to not retracting the foreskin was dated 8/27/16 and was listed under the problem of R3 recently having the corrective procedure (cutting of small slit) to relieve the tightened foreskin. These findings were reviewed with E1 (NHA), E2, E3 (ADON), and E4 (AED) at the exit conference on 9/22/16 at 11:45 AM.	F 279		
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and other interviews as indicated, it was determined for one (1) resident reviewed (R1) out of four (4) sampled residents, the facility staff failed to provide the necessary care and services for the resident's physical well-being. The facility failed to ensure staff performed cardiopulmonary resuscitation (CPR) in accordance with their training and certification and also failed to utilize available emergency equipment (Ambu-bag). In addition, the facility staff incorrectly moved R1 from the floor to the bed prior to initiating CPR and then performed chest compressions only	F 309	F309 A. R1 was discharged on 9/7/16 from the facility. E10 and E13 were re-educated on performing Cardio Pulmonary Resuscitation CPR) in accordance to their training and certification, and using emergency equipment (Ambu-bags) for providing ventilations; which are located in the patient□s room and the emergency cart. B. An audit was completed by the Director	11/8/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085032	A. BUILDING _____ B. WING _____	C 09/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMINSTER VILLAGE HEALTH	1175 MCKEE ROAD DOVER, DE 19904

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F 309	Continued From page 12 instead of performing both chest compressions and ventilations as they were trained to do. During chart review, it was also determined that facility staff administered R1's pain medication more frequently than allowed by physician order. Findings include: Cross-refer F157 and F279. (A) American Heart Association (AHA) Basic Life Support (BLS) instructions (updated in 2015) instruct healthcare providers to provide CPR by alternating 30 chest compressions with 2 breaths. There is no instruction to move a resident found on the floor to the bed as CPR is best done on a firm surface. Review of the clinical record for R1 and other documentation as indicated revealed the following: Personnel file documentation for E10 (RN) and E13 (LPN) revealed that:: -E10 was trained by E2 (DON) using the AHA training curriculum and re-certified as a BLS provider (CPR) with certification effective from 4/6/16 through 4/30/18;and -E13 was trained by E18 (RN) using AHA training curriculum in healthcare provider CPR with certification effective from 6/10/15 through 6/2017. R1 was admitted to the facility for short-term rehabilitation on 9/2/16 with a recent history of anoxic respiratory failure with hypoxia (inadequate breathing resulting in a lack of adequate oxygen to the body) requiring a tracheostomy, newly diagnosed heart problems,	F 309	of Nursing on residents with tracheostomies, which revealed one resident who was not affected. C. The crash carts on the unit have been stocked with 2 Ambu-bags each. Laminated American Heart Association (AHA) Cardio Pulmonary Resuscitation (CPR) guide cards have been placed in front of each crash cart for reference in case of emergencies. Nursing staff have been re-educated by Director of Nursing/Designee on: a. Performing CPR in accordance with the AHA training which is to utilize emergency equipment (Ambu-bag) during CPR; b. Leaving resident on the floor while performing CPR (if on the floor); c. Performing both chest and ventilations as trained and in accordance with the AHA guidelines; and d. Using the ambu-bag to ventilate a patient□s tracheostomy while performing CPR. D. DON/Designee will run mock emergencies monthly and re-educate as needed. Variances will be monitored and trended monthly in QAPI meetings for continued compliance. F 157 cross reference F 309 A. R1 was discharged on 9/7/16 from the facility. B. An audit was completed by the R.N. Supervisor, which revealed that no other residents were affected.	

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F 309	Continued From page 13 and newly diagnosed throat cancer. R1 signed a form dated 9/2/16 that she chose to be a full code. E7 (LPN) was interviewed on 9/11/16 at 3:10 PM and stated that she (E7) was the primary day shift nurse for R1 and that R1 was alert and oriented, able to walk, communicated with gestures and writing (unable to speak because of tracheostomy), and was independent with daily care activities. E7 stated that R1 status remained at this baseline between 9/2/16 and 9/6/16 when she last saw her. Clinical record documentation for the 11 PM to 7 AM shift on 9/7/16 revealed routine care had been provide to R1 including: -continuous oxygen via tracheostomy as ordered; -routine tracheostomy care at 1:07 AM; -a normal oxygen saturation result of 96%; and -receiving a dose of pain medication at 3:20 AM According to a nursing note dated 9/7/16 and timed 5:57 AM describing earlier events, R1 had asked to be suctioned (a procedure where a tube is placed into the airway to clear out secretions) and when E10 (RN) was about to do so R1 pointed to the bedside commode indicating that she wanted to use the commode first. E10 documented that he left the room telling R1 to call (using call bell) when she was finished. E10 wrote that about 6 minutes later, when R1 had not called, he returned to R1's room and found her lying on the floor with no pulse. E10 wrote that he called for help, CPR was initiated, and 911 was called. According to interview with E15 (911 Supervisor) on 9/13/16 at 8:35 AM, E16 (EMT) was the first	F 309	C. The EMR has been changed to reflect frequency and doses of previously administered pain medications under the comment tab. Nursing staff have been educated by Staff Development Coordinator/Designee on:- a.Checking the comment tab in the EMR for frequency and doses of previously administered pain medications, prior to administering the next dose. b.Calling the physician for changes in pain management in the event that the resident□s pain is not managed with the current physician orders. D. R.N. Supervisor/Designee will monitor PRN effectiveness report daily and intervene as needed. Variances will be monitored and trended monthly in QAPI meetings for continued compliance.	

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F 309	Continued From page 14	F 309		

responder to the 911 call from the facility arriving at R1's bedside at 4:42 AM. E16 stated to the surveyor on 9/13/16 at 8:55 AM that he observed E13 (LPN) and then E10 performing chest compressions on R1 who was in bed with a backboard under her torso. When asked if ventilations were being provided, E16 stated no and that he took over compressions from E10. When asked why he did not provide ventilations, E16 stated because he had heard on his radio that ALS had arrived. E16 stated that E11 (Paramedic) used the Ambu-bag from his (E16's) supply bag when they arrived several minutes later.

According to a Paramedic report dated 9/7/16, a 911 call was made by the facility at 4:32 AM for an unresponsive resident (R1) and E11 (Paramedic) arrived at R1's side at 4:46 AM.

The Paramedic report further documented that:
-facility staff reported to E11 that they had been performing CPR on R1, who was in bed, for about 10 minutes;
-E16 (EMT) was present in the room when E11 (Paramedic) arrived and reported to E11 that facility staff was doing chest compressions on R1 without ventilations;
-At 4:46 AM, E11 determined that R1's pupils were fixed and non-reactive (an abnormal finding indicating brain injury);
-At 4:54 AM, E11 requested but did not receive permission from the hospital emergency department physician to discontinue CPR;
-At 4:55 AM, R1 left the facility for the hospital in an ambulance;
-At 4:57 AM, E11 inserted a breathing tube into R1's tracheostomy, (about 11 minutes after E11's arrival time);

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F 309	Continued From page 15 -R1 arrived at the hospital at 5:02 AM; and -E11 documented that R1 had apparently had cardiac arrest (heart stopped beating) in the facility presumed to be cardiac in origin (heart issue caused heart to stop beating). The lack of ventilations provided to R1 by facility staff and the first responders to the 911 call was confirmed by staff interviews conducted by both a State survey agency investigator and a surveyor: -E10 (RN) reported on 9/8/16 at 10:15 AM that he found R1 on the floor, called out for help, lifted R1 onto the bed with the assistance of E12 (CNA) and E13 (LPN), and then he (E10) began chest compressions. When asked if an Ambu-bag was used, E10 replied no. E10 stated that had he seen one or known that an Ambu-bag was present he would have used it; -E12 (CNA) reported on 9/9/16 at 7:10 AM that after helping lift R1 onto the bed, she went and obtained a backboard off of the emergency supply cart ("crash cart") but did not bring the whole cart to the room. E12 stated that she saw E13 (LPN) doing chest compressions on R1; -E13 reported on 9/9/16 at 2:30 PM that he helped lift R1 onto the bed and that he and E10 alternated performing chest compressions. E13 stated that compressions were performed at a rate of 100 per minute and that no Ambu-bag was used to provide ventilations. Staff interviews, document review, and observations revealed that an Ambu-bag was available for staff to use: -E7 stated on 9/11/16 at 3:10 PM that the facility prepared for R1's admission by stocking her room with supplies that would be needed for her	F 309		

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F 309	Continued From page 16	F 309		

care including tracheostomy care equipment and an Ambu-bag for use in an emergency;
-Two (2) emergency supply carts ("crash carts") were observed near the unit where R1 resided during the days of the survey (9/11/16 through 9/22/16). Surveyor observation revealed that both carts contained an Ambu-bag in the bottom drawer; and
-A "Daily Emergency Cart Checklist" completed by facility staff on the 11 PM to 7 AM shift confirmed the presence of an Ambu-bag on the facility's emergency supply cart on 9/1/16 through 9/8/16.

An interview conducted after the exit with E19 (sister of R1) revealed that R1 was very independent with her activities of daily living and was able to tell when she needed to be suctioned. E19 stated that she would not expect staff to remain in the room with R1 if R1 was using the commode. E19 also stated that if R1 needed to be suctioned immediately she would have said so. E19 was asked if she had obtained the notepad used by R1 to communicate with facility staff and she stated that she had and there were no concerns written by R1.

In responding to R1's emergency situation, facility staff failed to provide CPR in accordance with their training and certification. The facility had ensured that emergency equipment (Ambu-bag) for providing ventilations (breaths) was available in R1's room and on the emergency supply cart, however, E10 and E13 failed to utilize this device. In addition, E10 and E13, with the assistance of E12 (CNA), lifted R1 off of the floor and put her in bed which is inconsistent with training that CPR is best done on a firm surface, where CPR was initiated. Multiple staff incorrectly performed CPR

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F 309	Continued From page 17 with the potential to adversely affect multiple residents. (B) R1 had multiple sources of pain including a history of back problems, a recent throat cancer diagnosis, and recent surgical procedures (tracheostomy and a feeding tube inserted into her abdomen). E8 (physician) wrote an order for a narcotic pain medication to be administered every 6 hours as needed with one (1) tablet for moderate pain (identified in the order as a self-rated score of 5 - 7 on a scale of 0 -10) or two (2) tablets for severe pain (identified in the order as a self-rated score of greater than 7 on a scale of 0-10). Medication Administration Record (MAR) documentation revealed the following doses administered less than six hours apart: -9/6/16 one tablet administered at 1:05 PM; -9/6/16 two tablets administered at 4:55 PM (3 hours and 50 minutes later); and -9/6/16 one tablet administered at 8:52 PM (3 hours and 57 minutes later). Surveyor record review revealed that the order for and dose of one (1) tablet was documented on one page of the computerized MAR while the order for and dose of two (2) tablets was documented on another page of the MAR. There was no evidence in the clinical record that the physician was notified about R1's need for more frequent pain medication. E8 (physician) had signed one order for pain medication which instructed staff to administer either one (1) tablet or two (2) tablets depending on how high R1's self-assessment of the pain level. This order, however, appeared on the MAR in two different	F 309		

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F 309	Continued From page 18 places meaning that nurses giving one (1) tablet signed off on one page while nurses giving two (2) tablets signed off on another page. Consequently, doses were erroneously given less than 6 hours apart on two occasions by the same nurse, E9 (RN) was interviewed by the surveyor on 9/14/16 at 6:30 PM and stated that she recalled R1 walking to the nursing station and asking for medication before it was time for another dose. E9 stated that the medication could not be given earlier than every 6 hours. Although there was a single physician's order for pain medication, the order gave facility staff the option of administering one (1) or two (2) tablets based on R1's self-assessment of the level of pain. The appearance of the order in two different places on the MAR and the failure of staff to check both places to see when the last does had been administered resulted in R1 receiving doses less than 4 hours apart on two occasions. On 9/19/16 at 3:04 PM, E8 confirmed that the frequency of pain medication administration he had ordered for R1 in his order dated 9/2/16 was every 6 hours, regardless of whether the dose given was one one (1) tablet or two (2). These findings were reviewed with E1 (NHA), E2, E3 (ADON), and E4 (AED) at the exit conference on 9/22/16 at 11:45 AM.	F 309		

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

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Westminster Village

DATE SURVEY COMPLETED: September 22, 2016

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 complaint survey was conducted at this facility from September 11, 2016 through September 22, 2016. The deficiencies cited in this report are based on record reviews, staff interviews, other interviews, and review of other facility documentation as indicated. The census the first day of the survey was 58. The sample size included two (2) active and two (2) closed records.		
3201	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.0	**Scope**		
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:** Cross Refer to the CMS 2567-L survey completed September 22, 2016: F157, F166, F250, F279, and F309.	Cross Refer to the CMS-2567L and POC submitted 10/20/2016 for F157, F166, F250, F279 and F309.	10/20/2016

Provider's Signature Mary Ann Privey, NHA Title Executive Director Date 10/20/16