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

DHSS - DHCQ
263 Chapman Road, Ste 200, Cambridge Bldg.
Newark, Delaware 19702
(302) 421-7400

**STATE SURVEY REPORT**



**NAME OF FACILITY:** Kutz Rehabilitation and Nursing **DATE SURVEY COMPLETED:** January 9, 2023

| SECTION | STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES | ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES | COMPLETION DATE |
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**Dementia training will be provided to E31, E34 and E35 by February 15, 2023.**

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| | **The State Report incorporates by reference and also cites the findings specified in the Federal Report.**<br><br>An unannounced Annual and Complaint Survey was conducted at this facility beginning January 3, 2023 and ending January 9, 2023. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and other documentation as indicated. The facility census on the entrance day of the survey was 68 residents. The investigative sample totaled 35. | | Completion Date: 03/10/2023 |
| **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.**<br><br>This requirement is not met as evidenced by:<br><br>Cross Refer to the CMS 2567-L survey completed 1/9/23: F550, F578, F580, F582, F585, F645, F655, F657, F684, F756, F758, F812, F851, F867, F868, F881, F943. | | |
| **3201.5.6** | **Dementia Training** | | |

Provider's Signature Tatiana L. Hall Title CEO, Administrator Date 02/03/2023

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| **3201.5.6.1**<br><br><br><br><br><br><br><br>**3201.5.6.2** | **Nursing facilities that provide direct healthcare services to persons diagnosed as having Alzheimer's disease or other forms of dementia shall provide dementia specific training each year to those healthcare providers who must participate in continuing education programs. This section shall not apply to persons certified to practice medicine under the Medical Practice Act, Chapter 17 of Title 24 of the Delaware Code.**<br><br>**The mandatory training must include: communicating with persons diagnosed as having Alzheimer's disease or other forms of dementia; the psychological, social, and physical needs of those persons; and safety measures which need to be taken with those persons.**<br><br>Based on interview and review of facility documentation as indicated, it was determined that the facility failed to ensure that the required training for dementia was completed for three (E31, E34 and E35) out of nine randomly sampled staff members. Findings include:<br><br>Review of facility submitted records revealed:<br><br>- 7/14/22 - The first day of assignment at the facility for E35 (LPN).<br>- 12/5/22 - The first day of assignment at the facility for E34 (RN).<br>- 1/2/23 - The first day of assignment at the facility for E31 (CNA).<br><br>1/6/22 5:21 - In an interview, E1 (NHA) confirmed that the above had not received dementia training. | 1. Dementia training will be provided to E31, E34 and E35 by February 15, 2023.<br><br>2. All staff hired since 7/1/2022 have the potential to be affected. All staff without dementia training will be provided by training by 2/15/2023.<br><br>3. RCA: This training was previously being performed at New Employee Orientation. The Orientation Days had been cancelled at times.<br><br>New employees are now assigned Dementia trainings on-line by the Human Resources (HR) Department , to be completed prior to their first assignment. The new employee is compensated for the time they are completing these webinars. The Nursing Scheduler confirms in the nursing education electronic system that the education has been completed prior to their first floor orientation day.<br><br>Nursing Home Administrator educated HR on the new process on 2/2/2023.<br><br>4. HR (or designee) will conduct audits of new hire training weekly 3 until 100% compliance is achieved. Audits will continue monthly x 2 until 100% compliance is achieved. Findings of the audits will be reported to the QAPI committee monthly x 3 months to ensure compliance is obtained and maintained. | |

Provider's Signature _____ Title __CEO, Administrator_____ Date 02/03/2023

**NAME OF FACILITY:** Kutz Rehabilitation and Nursing **DATE SURVEY COMPLETED:** January 9, 2023

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**Dementia training will be provided to E31, E34 and E35 by February 15, 2023.**

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| | 1/9/23 at 5:45 PM- Findings were reviewed during the Exit Conference with E1, E2 (DON), E3 (ADON) and E4 (AIT). | | |
| **9.0** | **Records and Reports** | | |
| **9.5** | **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.**<br><br>This requirement was not met as evidenced by:<br><br>Based on interview and review of the clinical record and the State Agency's (SA) Incident Report with a 5 day Follow-Up submitted by the facility, it was determined that for one (R58) out of three residents reviewed for falls, the facility failed to inform the SA of R58's injuries. Findings include:<br><br>Cross refer to 9.6<br><br>R58's clinical record revealed:<br><br>11/25/22 at 12:16 PM – A Physician's progress note documented that R58 was seen post fall on 11/24/22. Review of R58's diagnostic scan at the emergency room revealed an acute on chronic nasal (nose) bone fracture and soft tissue swelling greater in the right nasal region. | 1. No corrective action possible<br><br>2. Unable to correct retroactively<br><br>3. RCA: When resident returned from the Emergency Department, the wet read of the X-ray stated no new fracture and there was no mention of a CT Scan. The hospital did not forward final copies of any diagnostics, however one in-house Provider did view the results in the hospital EMR and note "acute on chronic" fracture in her documentation. When completing the State Reportable Follow Up, the staff was unaware of the final results and did not closely review the Provider notes.<br><br>A checklist was created for State Reportables that includes a thorough review of all Provider notes since the incident and review of current hospital records, including final radiographic diagnostics.<br><br>SDC or designee to educate all nurse managers on new process and checklist.<br><br>4. Director of Nursing or designee will conduct audits of resident falls requiring hospital transfer daily x 3 to ensure all records reviewed for updates, until 100% compliance is achieved. Audits will continue | |

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| | 11/28/22 – A Physician order documented "Please scheduled (sic) with ENT (Ears, Nose, Throat doctor) a nasal bone fracture follow up if family is in agreement."<br><br>11/30/22 - The facility's 5 day follow-up information submitted to the SA documented that R58 had no new injury. The facility documented "... No acute significant injury. Skin tear sustained during fall. No nose injury noted s/p (status post) x-ray (diagnostic test) and MD (Medical Doctor) assessment. Resident returned from ER < (less than) 24 hours with no acute injury... No new orders."<br><br>1/9/23 at 1:26 PM – During an interview, finding was reviewed with E1 (NHA) and E4 (AIT).<br><br>1/9/23 at 5:45 PM - Finding was reviewed during the Exit Conference with E1, E2 (DON), E3 (ADON) and E4. | weekly x 3, until 100% compliance is achieved. Audits will continue monthly x 2 until 100% compliance is achieved. Findings of the audits will be reported to the QAPI committee monthly x 3 months to ensure compliance is obtained and maintained. | |
| 9.6<br><br>9.8<br><br>9.8.4.2 | **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.**<br><br>**Reportable Incidents are as follows:**<br><br>**Injury which results in transfer to an acute care facility for treatment or evaluation.**<br><br>This requirement was not met as evidenced by:<br><br>Based on interview and review of the clinical record and the State Agency's (SA) Incident Report, it was determined that the facility failed to report R58's 11/23/22 fall with injury that resulted in transfer to an acute care facility for evaluation. Findings include: | 1. Unable to correct for this resident<br><br>2. Audit produced no other residents at risk of deficient practice<br><br>3. ***RCA:*** When the DON arrived in the morning, E11 notified her of the fall. Staff member had just been rehired and had forgotten about doing the state report. The DON did a just in time education with E11, explaining the reports had to be in within 8 hours. E11 said she thought it was 24 hours not 8. She then put the report in, however it was beyond the 8-hour mark at that time. | |

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| | Cross refer to 9.5<br><br>R58's clinical record revealed:<br><br>11/24/22 at 12:10 AM – A Nurse's note documented that R58 was found sitting on her bedroom floor with blood noted to the face, outer aspect of right hand and on the floor behind the resident. R58 was unable to say what happened. R58's had an L shaped skin tear to her right hand, bruising noted to her forehead and between her eyes, and her nose was slightly deviated (displaced to one side) to the right. The Physician was notified on 11/23/22 at 11:00 PM and R58's resident representative was notified on 11/23/22 at 11:30 PM. R58 was transferred to the emergency room for further evaluation at 12:00 midnight.<br><br>According to the SA's Incident Report, the facility reported R58's fall on 11/24/22 at 9:10 AM, which was over the eight hour reporting requirement.<br><br>1/9/23 at 1:26 PM – During an interview, finding was reviewed with E1 (NHA) and E4 (AIT).<br><br>1/9/23 at 5:45 PM – Finding was reviewed during the Exit Conference with E1, E2 (DON), E3 (ADON) and E4. | During weekday daily Clinical Rounds, all resident falls requiring transfer to acute care will be reviewed for timeliness of reporting.<br><br>SDC or designee will educate licensed staff, regarding the requirement to report to the State of Delaware any fall requiring transfer within 8 hours of the occurrence of the incidence.<br><br>4. The DON, or their Designee will audit all falls requiring transfer daily x 3 to ensure that they are reported within 8 hours, until 100% compliance is achieved. Audits will continue weekly x 3, until 100% compliance is achieved. Audits will continue monthly x 2 until 100% compliance is achieved. Findings of the audits will be reported to the QAPI committee monthly x 3 months to ensure compliance is obtained and maintained. | |

Provider's Signature _____ Title __CEO, Administrator_____ Date 02/03/2023

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 085043 | A. BUILDING _____ B. WING _____ | C 01/09/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| KUTZ REHABILITATION AND NURSING | 704 RIVER ROAD WILMINGTON, DE 19809 |

| (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 |
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| E 000 | Initial Comments<br><br>An unannounced Emergency Preparedness Survey was conducted at this facility beginning January 3, 2023 and ending January 9, 2023 by the State of Delaware Division of Health Care Quality, Office of Long Term Care Residents Protection in accordance with 42 CFR 483.73. The facility census the first day of the survey was 68.<br><br>For the Emergency Preparedness Survey, all contracts, operation plans, contact information, and annual emergency drills were up to date. No deficiencies were identified. | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>An unannounced Annual and Complaint Survey was conducted at this facility beginning January 3, 2023 and ending January 9, 2023. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and other documentation as indicated. The facility census on the entrance day of the survey was 68 residents. The investigative sample totaled 35.<br><br>Abbreviations/definitions used in this report are as follows:<br><br>AIT - Administrator in Training;<br>CNA - Certified Nurse's Aide;<br>CP - Consultant Pharmacist;<br>DON - Director of Nursing;<br>EMR- Electronic Medical Records;<br>GDR- gradual dosage reduction;<br>ICP - Infection Control Preventionist;<br>LPN - Licensed Practical Nurse;<br>MAR- Medication Administration Record; | F 000 | | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Electronically Signed | | 02/03/2023 |

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<br>MD - Medical Director;<br>NHA - Nursing Home Administrator;<br>NP - Nurse Practitioner;<br>O2 - oxygen;<br>PC - Pharmacy Consultant;<br>RN - Registered Nurse;<br>TAR- Task Administration Record:<br><br>Cognition - mental process; thinking;<br>COVID 19/Coronavirus - a respiratory illness that can be spread person to person;<br>Minimum Data Set (MDS) - standardized assessment forms used in nursing homes;<br>Nasal cannula- tube placed into nostrils to deliver oxygen;<br>Neurogenic bladder - a person lacks bladder control due to a brain, spinal cord, or nerve condition;<br>Nosocomial -an infection acquired in a health care-facility;<br>Psychotropic Medications -any medications capable of affecting the mind, emotions and behaviors;<br>Pulse Oximetry - measures blood oxygen saturation levels - desired range 94% to 100%;<br>O2 < (less than) 90% - blood oxygen saturation level is below the desired range of 94%-100%;<br>Oxygen saturation - measures how much oxygen is traveling through the body in the red blood cells;<br>Severely impaired cognition - severely impaired mental process/thinking. | F 000 | | |
| F 550 SS=D | Resident Rights/Exercise of Rights<br>CFR(s): 483.10(a)(1)(2)(b)(1)(2)<br><br>§483.10(a) Resident Rights.<br>The resident has a right to a dignified existence, self-determination, and communication with and | F 550 | | 3/10/23 |

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| F 550 | Continued From page 2<br>access to persons and services inside and outside the facility, including those specified in this section.<br><br>§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.<br><br>§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.<br><br>§483.10(b) Exercise of Rights.<br>The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.<br><br>§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.<br><br>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.<br>This REQUIREMENT is not met as evidenced by:<br>Based on random observations and interview, it | F 550 | 1. Education provided to E8 regarding | |

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| F 550 | Continued From page 3<br>was determined that for three (R16, R62 and R68) out of three residents reviewed for dignity, the facility failed to ensure that care was provided in a way that promoted dignity. Findings include:<br><br>1. Review of R62's clinical record revealed:<br><br>11/5/21 - R62 was admitted to the facility with dementia.<br><br>6/7/22 9:00 AM - A Physician's order included: Lidocaine (pain) Patch. Apply to left shoulder and right knee in the morning for chronic pain.<br><br>1/06/23 8:48 AM - During an observation of a medication pass, E8 (LPN) pulled back R62's covers, exposed her incontinence brief, both upper thighs,and applied a pain patch to R62's right knee. During the application of the pain patch, R62's door was open, the privacy curtain was not closed and R62 could be visualized by staff and/or visitors from the hallway.<br><br>1/6/23 8:55 AM - During an interview, E8 confirmed that he failed to provide privacy for R62 by exposing R62's private body parts to the hallway where others could visualize her being administered her pain patch.<br><br>2. Review of R16's clinical record revealed:<br><br>12/30/21 - R16 was admitted to the facility.<br><br>1/9/22 (revised 7/29/22) - A care plan was initiated for R16's chronic use of an indwelling catheter (small tube used to drain urine from the bladder) related to neurogenic bladder with interventions including positioning the catheter (urinary) bag and tubing...away from entrance the | F 550 | importance of making sure privacy is always maintained when having to expose residents body parts verbally on 1/3/2023 by ADON.<br><br>2. Unable to identify other residents affected retroactively.<br><br>3. RCA: E8 was not aware that he could ask the surveyors to move out of the doorway so he could close the door. He did not pull the curtain because he thought the 3 surveyors were observing him as a part of his Medication Pass.<br><br>SDC to educate all licensed staff that privacy must always be maintained when applying patches, regardless of who is in the room. Privacy curtains must be pulled and/or doors closed.<br><br>4. Nursing Supervisor (or designee) will conduct audits of residents requiring patches daily x 3 to ensure that privacy is maintained, until 100% compliance is achieved. Audits will continue weekly x 3, until 100% compliance is achieved. Audits will continue monthly x 2 until 100% compliance is achieved. Findings of the audits will be reported to the QAPI committee monthly x 3 months to ensure compliance is obtained and maintained.<br><br>1. Privacy covering was applied over urinary bag for R16 and R68 on 1/4/2023 by assigned CNAs.<br><br>2. All other residents with urinary catheters have potential to be affected by | |

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| F 550 | Continued From page 4<br>room door.<br><br>Multiple observations in the Garden Club (200 Hall activity and dining lounge) on 1/3/23 at 10:26 AM, 11:30 AM at 2:30 PM, and at 11:45 AM on 1/4/23, revealed R16 lying in her Geri chair (a large padded medical recliner chair) with a urinary drainage bag visible in the lounge and in the hallway. The collection bag was approximately half filled with amber urine. It was not covered and was visible to anyone passing by in the lounge and in the hallway.<br><br>1/5/23 - Review of R16's kardex (CNA plan of care for individual residents) documented that R16's urinary bag and tubing were to be positioned away from the entrance room door.<br><br>1/5/23 10:33 AM - During an interview, E23 (CNA) confirmed that R16's urinary bag was not covered the past few days.<br><br>1/6/23 4:25 PM - Findings were discussed with E2 (DON).<br><br>3. Review of R68's clinical record revealed the following:<br><br>7/18/22 - R68 was admitted to the facility.<br><br>9/23/22 (revised 11/2/22) - A care plan was initiated for R68's use of an indwelling suprapubic catheter (tube used to drain urine from the bladder) related to neurogenic bladder with interventions including positioning the urinary bag and tubing...away from the entrance room door.<br><br>1/3/23 1:58 PM - R68 was observed operating his motorized wheelchair across the 200 hall going to | F 550 | the deficient practice of urinary bags being exposed. On 1/4/2023, an audit was completed on all residents who have urinary bags for privacy covering.<br><br>3. RCA: There was no Task listed in Point Click Care (PCC) for the CNA□s to document Privacy Covering. Urinary bags and privacy covers were not stored in the same place, nor easily assessable to CNA staff.<br>Task was added to PCC for the CNA□s to document Privacy Covering. A Privacy Covering was placed with each Urinary bag in the supply area. When the current supply of Urinary Bags is exhausted it will be replaced with a Urinary Bag that has a Fig Leaf Cover permanently attached.<br><br>SDC or designee will educate all direct care staff on the need to have the urinary bag covered to maintain residents□ dignity.<br><br>4. Nurse Supervisor or designee will conduct audits of residents with urinary bags daily x 3 to ensure bags are covered, until 100% compliance is achieved. Audits will continue weekly x 3, until 100% compliance is achieved. Audits will continue monthly x 2 until 100% compliance is achieved. Findings of the audits will be reported to the QAPI committee monthly x 3 months to ensure compliance is obtained and maintained. | |

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| F 550 | Continued From page 5<br>the 300 hall. R16's urinary bag had approximately 200 mL (milliliters) of amber urine, was not covered, and was visible to visitors, residents and staff in the hallways.<br><br>1/5/23 10:30 AM - During an interview, R68 stated that the CNA put the privacy bag over R68's urinary bag yesterday afternoon, "around 5 PM."<br><br>1/6/12 4:25 - Findings were discussed with E2 (DON).<br><br>1/9/22 at 5:45 PM - Findings were reviewed during the Exit Conference with E1 (NHA), E2 (DON), E3 (ADON) and E4 (AIT). | F 550 | | |
| F 578 SS=D | Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v)<br><br>§483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.<br><br>§483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.<br><br>§483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).<br>(i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. | F 578 | | 3/10/23 |

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| F 578 | Continued From page 6<br>(ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.<br>(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.<br>(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law.<br>(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information.<br>Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and interview, it was determined that for one (R37) out of twenty-four residents reviewed for advanced directives, the facility failed to ensure consistent, accurate and up to date records of R37's code status. Findings include:<br><br>Review of R37's clinical record revealed:<br><br>9/17/17 - R37 was admitted to the facility.<br><br>1/18/18 - A Physician's order included that R37 was a full code. (R37 would like CPR if she became unresponsive). R37's electronic medical record (EMR) revealed that R37 was documented in her EMR ribbon as a full code. | F 578 | 1. The code status order for R37 was immediately corrected in Point Click Care (PCC), the electronic medical Record, on 01/03/2023 by Staff Development.<br><br>2. All residents have the potential to be affected by a code status that is not consistent, accuate and up to date. An audit of all resident orders was completed on 1/3/2023 by the DON to ensured all orders in PCC matched the official signed DMOST forms.<br><br>3. RCA: When a new DMOST was signed by resident/representative, licensed staff put the form in the Provider binder for signature. The provider would | |

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| F 578 | Continued From page 7<br>10/19/22 - A DMOST (Delaware Medical Orders For Scope of Practice - Advanced Directive for healthcare) was signed by R37, R37's Power of Attorney (financial/care), and the Physician documented that R37 wished to be a DNR (Do not resuscitate in the event that R37's heart or breathing stopped).<br><br>1/03/23 1:50 PM During an interview, E9 (RN) confirmed that the facility Nurses, in the event that a resident becomes unresponsive, look for the code status (DNR or full code) in the Physician's orders and the resident ribbon in the EMR. E9 confirmed that R37's most recent code status (per the DMOST) was to be a DNR, and that R37 did not have a physician's order to be a DNR. E9 also confirmed that R37's code status was not consistent, accurate, and up to date with R37 and her Power of Attorney's wishes for R37 to be a DNR.<br><br>1/9/23 at 5:45 PM - Findings were reviewed during the Exit Conference with E1 (NHA), E2 (DON), E3 (ADON) and E4 (AIT). | F 578 | sign the form and place it in a bin that included other documents. There was no process in place to alert the licensed staff to review the form to to update the order or ensure an order was placed and some staff simply scanned and filed the form.<br><br>The process for handling a new DMOST was updated. When the Provider receives a new DMOST form, they will immediately update the order in PCC upon signing the DMOST. The Provider will hand deliver the signed DMOST to a Nurse Manager. Licensed staff will verify provider signature on DMOST form and confirm order in PCC making it active.<br><br>SDC to educate all Nurse Managers on the DMOST process.<br><br>4. Nurse Supervisors on evening shift or designee will conduct audit of residents code status daily x 3 to ensure all completed DMOST forms match resident code status in PCC, until 100% compliance is achieved. Audits will continue weekly x 3, until 100% compliance is achieved. Audits will continue monthly x 2 until 100% compliance is achieved. Findings of the audits will be reported to the QAPI committee monthly x 3 months to ensure compliance is obtained and maintained. | |
| F 580 SS=D | Notify of Changes (Injury/Decline/Room, etc.)<br>CFR(s): 483.10(g)(14)(i)-(iv)(15)<br><br>§483.10(g)(14) Notification of Changes.<br>(i) A facility must immediately inform the resident; | F 580 | | 3/10/23 |

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| F 580 | Continued From page 8<br>consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-<br>(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;<br>(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);<br>(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<br>(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).<br>(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.<br>(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-<br>(A) A change in room or roommate assignment as specified in §483.10(e)(6); or<br>(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.<br>(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).<br><br>§483.10(g)(15)<br>Admission to a composite distinct part. A facility | F 580 | | |

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| F 580 | Continued From page 9<br>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).<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, interview and review of facility policy, it was determined that for one (R476) out of one resident reviewed for death, the facility failed to ensure immediate notification with the residents Attending Physician when R476 experienced a change in respiratory status. R476's oxygen saturation decreased to under 90%. Additionally, the facility failed to notify R476's responsible party of the change in respiratory status resulting in the implementation of as needed respiratory interventions. Findings include:<br><br>Review of National Institutes of Health webpage indicated, "Oxygen saturation levels around 96% to 100% are considered normal. "https://www.ncbi.nlm.nih.gov/books/NBK470348.<br><br>The facility policy on Change in a Resident's Condition or Status last updated 12/2022, indicated, "The nurse or nursing supervisor will notify the resident's attending physician or on-call physician when there has been a significant change in the residents physical/emotional, mental condition; A need to alter the residents medical treatment; The Nurse/Nursing supervisor will notify the residents representative when there has been a significant change in the residents physical/emotional, mental condition; there is a change in the plan of care of the resident. Except | F 580 | 1. Resident no longer at facility, no opportunity to correct.<br><br>2. All residents with conflicting Standing PRN (as needed) orders related to Oxygen have the potential to be affected. All resident orders audited with conflicting orders corrected by nursing supervisor on 2/2/2023<br><br>3. RCA: Staff was following the Standing PRN Oxygen order, which does not instruct to call the provider. There is an addition COVID monitoring order which states call Provider for Oxygen Saturation less than 90% which was intended to monitor signs and symptoms of COVID. The application of the Oxygen was effective; therefore, the Staff did not consider it a significant change, did not report immediately to the Provider or the family. Staff had ruled out COVID with a rapid test and therefore did not call the Provider.<br><br>Both orders were updated to call provider and resident representative if Oxygen is not effective within ten minutes.<br><br>SDC or designee to educate all licensed | |

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| F 580 | Continued From page 10<br>in medical emergencies notifications will be made within twelve hours of a change occurring."<br><br>Review of R476's clinical record revealed:<br><br>8/1/17- R476 was admitted to the facility.<br><br>8/1/17 - A physicians order was written for R476 to receive Oxygen 2-4 liters by nasal cannula or facemask for Dyspnea (difficulty breathing) as needed.<br><br>3/28/20 - A physician's order was written for R476 to have temperature and pulse oxygen (oxygen saturation) checked daily. If the temperature was 100 degrees or greater or if there was any abnormal low temperature and pulse oxygen report to Physician immediately.<br><br>3/2/21- R476's care plan for the risk for COVID-19 included interventions to check the temperature and pulse oxygen daily. Monitor vitals signs as ordered/needed with any signs or symptoms of respiratory illness. Promptly notify MD/Supervisor if any of the following are noted: trouble breathing/O2 Saturation <90%.<br><br>10/21/21 - A quarterly MDS assessment documented R476 was cognitively impaired, had no shortness of breath and required no oxygen treatment.<br><br>11/4/21- A physicians order was written for R476 to receive Albuterol nebulizer (breathing) treatments, 1 vial inhale every 6 hours as needed for shortness of breath and/or wheezing as needed.<br><br>11/7/21 1:15 AM - E7 (RN) documented in an | F 580 | staff of the new Oxygen order and COVID monitoring order, as well as reinforce documentation of all calls to resident representatives when providers are called.<br><br>4. Unit Manager, or designee, will conduct 24-hour nursing report review to ensure that Provider and Resident representative are notified if Oxygen is not effective within ten minutes daily x 3 days until100% compliance is achieved. Audits will continue weekly x 3 weeks until 100% compliance is achieved. Audits will continue monthly x 3 until 100% compliance is achieved. Findings of the audits will be reported to the QAPI committee monthly x 3 months to ensure compliance is obtained and maintained. | |

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| F 580 | Continued From page 11<br>order administration note in R476's clinical record administration of "...01:00 [AM]-Resident oxygen saturation 89% on room air, not in any apparent distress. Noted with low grade temp 99.7. Skin warm to touch oxygen applied at 2 liters nasal cannula...02:00 [AM]-Temp: 98.6 and oxygen saturation 94%. 02 discontinued, resident breathing with no difficulty. Logged in physician book for follow-up. The clinical record lacked evidence that E7 immediately notified a physician regarding R476's low oxygen saturation.<br><br>11/10/21 8:39 PM - E10 (LPN) documented in a nurses note, "Resident in bed, with eyes open, oxygen at three liters by nasal cannula. On assessment, lungs clear to auscultation [sound], occasional cough noted. No respiratory distress noted at this time. Vital signs as follows: 98.1-80-18-130/69-POX [oxygen saturation] 94% on three liters. RR [resident representative/responsible party {RP1}]/daughter notified of resident's status. Resident to be assessed by house MD tomorrow." Review of the clinical record revealed that this was the first notification provided to R476's RP of the residents respiratory status.<br><br>During an interview on 1/5/23 at 1:21 PM with RP1, it was reported that RP1, "They [the facility] called the night of [11/14/22] R476's hospitalization and said they were putting back on her oxygen and I had never known she was on it."<br><br>During an interview on 1/9/23 at 10:37 AM E7 (RN) confirmed the above nurses note that lacked evidence that a Physician was immediately notified of R476's low oxygen level. E7 stated, "R476 was not in any distress, I put it in the book." | F 580 | | |

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| F 580 | Continued From page 12<br><br>1/9/22 at 5:45 PM - Findings were reviewed during the Exit Conference with E1 (NHA), E2 (DON), E3 (ADON) and E4 (AIT). | F 580 | | |
| F 582 SS=D | Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v)<br><br>§483.10(g)(17) The facility must--<br>(i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of-<br>(A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged;<br>(B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and<br>(ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section.<br><br>§483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.<br>(i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.<br>(ii) Where changes are made to charges for other items and services that the facility offers, the | F 582 | | 3/10/23 |

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| F 582 | Continued From page 13<br>facility must inform the resident in writing at least 60 days prior to implementation of the change.<br>(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.<br>(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility.<br>(v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and interview, it was determined that for two (R25 and R68) out of three residents reviewed for the beneficiary protection notice review, the facility failed to provide the Skilled Nursing Facility Advanced Beneficiary Notice (SNF ABN) when the residents were discharged from Medicare Part A Services and remained in the facility. Findings include:<br><br>1. Review of R25's clinical record revealed:<br><br>12/2/22 - R25 was admitted to the facility.<br><br>12/15/22 - R25 was discharged from Medicare Part A services and continued to remain in the facility.<br><br>1/6/23 - Evidence of the required SNF ABN form | F 582 | 1. As a corrective action, LSW will contact R25 and R68, or their resident representatives, affected and explain the SNF ABN form to them and obtain signatures by 2/2/23.<br><br>2. All residents who were initially Medicare A admissions and remained in the facility have the potential to be affected.<br><br>LSW to audit potentially affected residents since July, 2022 and provide SNF ABN form if necessary by February 28, 2023<br><br>3. RCA: Due to a lack of knowledge on the part of facility licensed social worker the facility failed to provide the applicable | |

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| F 582 | Continued From page 14<br>was not provided on the completed beneficiary protection notification worksheet for R25.<br><br>2. Review of R68's clinical record revealed:<br><br>7/18/22 - R68 was admitted to the facility.<br><br>9/13/22 - R68 was discharged from Medicare Part A services and continued to remain in the facility.<br><br>1/6/23 - Evidence of the required SNF ABN form was not provided on the completed beneficiary protection notification worksheet for R68.<br><br>During an interview on 1/6/23 at 10:55 AM with E6 (SSD), the above findings were confirmed. E6 stated she was unaware that residents who remained in the facility were to receive SNF ABN forms.<br><br>1/9/22 at 5:45 PM - Findings were reviewed during the Exit Conference with E1 (NHA), E2 (DON), E3 (ADON) and E4 (AIT). | F 582 | residents with SNF ABN forms. LSW was hired in July of 2022 and as a new long-term care social worker was not aware that a SNF ABN form needed to be provided to applicable residents. LSW was not trained by the preceding social worker about SNF ABN forms.<br><br>LSW to create a check list which will be utilized by all disciplines that attend Utilization Review meetings weekly to ensure that all SNF ABN forms are being signed. LSW will use a personal calendar to alert her when SNF ABN forms need to be signed. MDS coordinator to act as the back-up in the event that social work is unavailable to explain/ obtain signatures on these forms.<br><br>NHA educated LSW and LNAC on 1/11/2023 on SNF ABN.<br><br>4. LSW or their designee, will audit to ensure that all resident□s that remain at Kutz after a Medicare part A stay receive and sign a SNF ABN form. LSW will audit 3 resident charts a week until it is determined that 100% compliance is achieved starting 1/30/23. | |
| F 585 SS=D | Grievances<br>CFR(s): 483.10(j)(1)-(4)<br><br>§483.10(j) Grievances.<br>§483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with | F 585 | | 3/10/23 |

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| F 585 | Continued From page 15<br>respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay.<br><br>§483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.<br><br>§483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.<br><br>§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:<br>(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman | F 585 | | |

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| KUTZ REHABILITATION AND NURSING | 704 RIVER ROAD WILMINGTON, DE 19809 |

| (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 |
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| F 585 | Continued From page 16<br>program or protection and advocacy system;<br>(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;<br>(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;<br>(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;<br>(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;<br>(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement | F 585 | | |

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| F 585 | Continued From page 17<br>Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and<br>(vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interviews, record reviews and review of other facility documentation as indicated, it was determined that the facility failed to ensure that grievances received by the facility included prompt efforts to resolve concerns for one (R477) out of two residents sampled for grievance review. In addition, the facility failed to ensure that a written resolution was issued to the complainant. Findings include:<br><br>Review of the facility's Grievance Policy, dated September 2019, indicated:<br>-Grievances must normally be submitted in writing; if a complaint is made verbally which is to be moved forward as a grievance, the details must be recorded in writing on the grievance form before proceeding...<br>- The Grievance Official or designee will then as soon as reasonably possible review the grievance and conduct an investigation by discussing the grievance with the complainant, as well as others as appropriate. Corrective actions will be taken as appropriate and the grievance outcome will be reported to the interdisciplinary team...<br>-After investigation is complete, the person registering the grievance and any relevant parties will be notified of their resolution.<br><br>12/6/21 - FM1 (Family Member) emailed E2 (DON) regarding R477's missing clothes | F 585 | 1. R477 is no longer in the facility, so unable to correct.<br><br>2. All residents with grievances have the potential to be affected. The LSW to audit all grievances since July 2022, to ensure written resolution of all possible outstanding grievances.<br><br>3.RCA: Due to the fact that there was not a social worker in the building at the time to monitor and record grievances nursing was held solely responsible to oversee the grievance process. Due to staffing challenges, nursing was unable to dedicate the time to provide written follow-up on resident concerns.<br>As of July 2022 LSW receives grievances and inputs them into Record of Concern/ Complaint and then follows up with all appropriate members of the interdisciplinary team to come to a resolution. LSW communicates with residents/ resident representatives about the resolution via email or over the phone in a timely manner. LSW then types up the resolution detailing the date that the resident/ representative was notified of the resolution. All grievances are then printed and placed into a binder which is | |

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| F 585 | Continued From page 18<br>consisting of pajamas, underwear or camisoles, several pairs of slacks, two cardigan sweaters, shirts and pullover sweatshirts. The facility lacked evidence that this email was documented, the Record of Concern/Complaint was completed, and a documented resolution and agreement with the complainant was on file.<br><br>12/26/21 - The facility's Record of Concern/Complaint report documented that FM1 sent a letter of complaint via email regarding R477's care and change in behavior. The Record of Concern/Complaint did not document evidence of a resolution and agreement with FM1.<br><br>There was a lack of evidence that the complainant was informed of the findings of the investigation and that actions were taken to correct the identified concerns.<br><br>2/28/22 - FM1 emailed E3 (ADON) regarding R477's missing comforter and quilt. The facility lacked evidence that this email was documented in the Record of Concern/Complaint and a documented resolution and agreement with the complainant was on file.<br><br>3/23/22 - FM1 emailed E2 regarding a request of the timestamp of R477's fall on 3/18/22. The facility lacked evidence that this email was documented in the Record of Concern/Complaint and a documented resolution and agreement with the complainant was on file.<br><br>The facility lacked evidence that the multiple emails from FM1 concerning R477 were identified as grievances. In addition, the facility lacked evidence that the Record of Concern/Complaint was completed and a documented resolution and | F 585 | located in the social services office.<br>To ensure that grievances are not overlooked or missed, LSW developed a grievance log to ensure that each complaint is logged and resolved in a timely manner.<br><br>4. LSW to audit the grievance log daily X3 until 100% compliance is achieved, then 3 times in 1 week until 100% compliance is achieved, and then 1X a week X3 weeks until 100% compliance is achieved to ensure that all complaints/ grievances have a timely resolution documented on the grievance form. | |

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| F 585 | Continued From page 19<br>agreement with the complainant was on file.<br><br>1/6/23 8:35 AM - During an interview, FM1 stated that R477 was missing a lot of clothes, including blankets which took weeks for the facility to retrieve. FM1 also stated she had to call the facility and asked to check the clothes herself in the laundry room, where she found some of R477's clothes folded and stacked on a shelf.<br><br>1/6/23 8:40 AM - Further interview with FM1 stated, "... The facility took almost a week to give me an explanation and a timestamp on how my mother fell on 3/18/22."<br><br>1/6/23 5:20 PM - During an interview, E2 stated that she handled all residents' grievances until the facility was able to hire E6 (SSD) in July 2022. E6 took over as the Grievance Officer and started organizing and filing the grievance logs, investigating and completing the grievance reports and was following the process. E2 confirmed that all the email correspondences with FM1 concerning R477 were not documented in the Record of Concerns/Complaints form. E2 further confirmed that the facility did not have a documented resolution and agreement with FM1 on file.<br><br>1/9/23 1:30 PM - During an interview, E1 (NHA) stated that any concerns pertaining to R477 at that time were forwarded to E2 who was the person in charge for grievance follow up. E1 also stated there were a lot of staffing challenges at that time until the facility was able to hire E6 in July 2022 to take over as the new Grievance Officer.<br><br>1/9/22 at 5:45 PM - Findings were reviewed | F 585 | | |

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| F 585 | Continued From page 20<br>during the Exit Conference with E1, E2 (DON), E3 (ADON) and E4 (AIT). | F 585 | | |
| F 645 SS=D | PASARR Screening for MD & ID<br>CFR(s): 483.20(k)(1)-(3)<br><br>§483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability.<br><br>§483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with:<br>(i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission,<br>(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and<br>(B) If the individual requires such level of services, whether the individual requires specialized services; or<br>(ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission-<br>(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and<br>(B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.<br><br>§483.20(k)(2) Exceptions. For purposes of this section- | F 645 | | 3/10/23 |

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| F 645 | Continued From page 21<br>(i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.<br>(ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual-<br>(A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,<br>(B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and<br>(C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services.<br><br>§483.20(k)(3) Definition. For purposes of this section-<br>(i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1).<br>(ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and interview, it was determined that for two (R56 and R60) out of two sampled residents reviewed for Preadmission Screening and Resident Review (PASRR) Level I, the facility failed to have currently dated PASRR Level I Screenings. Findings include: | F 645 | 1. LSW completed new PASRRs for R56 and R60 on January 10, 2023.<br><br>2. All newly admitted residents have potential to be affected. LSW to audit all admissions since 11/2/2022 to ensure | |

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| F 645 | Continued From page 22<br><br>1. Review of R56's clinical record revealed:<br><br>10/17/22 - R56 received a Notice of Level I PASRR Screening Outcome letter with an approval period of sixty (60) days. The Level I PASRR Outcome Explanation in paragraph #3 stated: "If you or your care provider thinks that you need to stay longer than the Number of Approved Days listed on the Notice of PASRR Level I Screen Outcome that came with this letter, a nursing facility staff member must submit a new Level I screen ...This must be completed by or before the last approved day after your admission to the nursing facility."<br><br>10/18/22 - R56 was admitted to the facility.<br><br>1/3/22 - Record review revealed that the 10/17/22 Level I PASRR Screening that expired 12/16/22, was the only Level I PASRR Screening present for R56.<br><br>1/5/23 4:56 PM - During an interview, E6 (SW) confirmed that R56's record contained the 10/17/22 Level I PASRR Screening with an approval period of 60 days and that a new Level I PASRR Screening had not been completed.<br><br>2. Review of R60's clinical record revealed:<br><br>11/2/22 - R60 was admitted to the facility.<br><br>1/3/22 - Record review revealed that a Level I PASRR Screening was not present in the record for R60.<br><br>1/5/23 1:56 PM - During an interview, E6 (SW) confirmed that R60's record did not contain a | F 645 | PASRR completed by February 15, 2023.<br><br>3. RCA: As of November 2nd, 2022 licensed social worker (LSW) became responsible for PASRR completion. Due to lack of knowledge about the PASRR system and lack of training from Admissions Director, LSW was unaware that these two PASRR□s had expired.<br><br>LSW updated the social work admissions checklist to reflect the need for PASRR completion. Additionally, LSW to add any PASRR expiration dates to a personal calendar to keep track of due dates.<br><br>On 1/11/23 LSW completed Delaware Health Care Facilities Association PASRR 101 training online.<br><br>4. LSW to audit for PASRR compliance daily X 3 until 100% compliance is achieved, then weekly x 3 until 100% compliance is achieved, and then monthly x 2 until 100% compliance is achieved. Findings of the audits will be reported to the QAPI committee monthly x 3 months to ensure compliance in obtained and maintained. | |

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| F 645 | Continued From page 23<br>Level I PASRR screening.<br><br>1/5/23 3:00 - During an interview, E6 provided a 9/12/22 Level I PASRR Screening for R60 with an approval period of 60 days, with an expiration date of 11/11/22. The Level I PASRR Outcome Explanation in paragraph #3 stated: "If you or your care provider thinks that you need to stay longer than the Number of Approved Days listed on the Notice of PASRR Level I Screen Outcome that came with this letter, a nursing facility staff member must submit a new level I screen ...This must be completed by or before the last approved day after your admission to the nursing facility." E6 acknowledged that a new Level I PASRR for R60 wasn't completed.<br><br>1/9/23 at 5:45 PM - Findings were reviewed during the Exit Conference with E1 (NHA), E2 (DON), E3 (ADON) and E4 (AIT). | F 645 | | |
| F 655 SS=D | Baseline Care Plan<br>CFR(s): 483.21(a)(1)-(3)<br><br>§483.21 Comprehensive Person-Centered Care Planning<br>§483.21(a) Baseline Care Plans<br>§483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must-<br>(i) Be developed within 48 hours of a resident's admission.<br>(ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to-<br>(A) Initial goals based on admission orders. | F 655 | | 3/10/23 |

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| F 655 | Continued From page 24<br>(B) Physician orders.<br>(C) Dietary orders.<br>(D) Therapy services.<br>(E) Social services.<br>(F) PASARR recommendation, if applicable.<br><br>§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-<br>(i) Is developed within 48 hours of the resident's admission.<br>(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).<br><br>§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:<br>(i) The initial goals of the resident.<br>(ii) A summary of the resident's medications and dietary instructions.<br>(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.<br>(iv) Any updated information based on the details of the comprehensive care plan, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on review of the clinical record it was determined that for one (R475) out of two residents reviewed for admission, the facility failed to develop a baseline care plan within 48 hours of the resident's admission. Findings include:<br><br>R475's clinical record revealed:<br><br>11/2/22 - R475 was admitted to the facility for a | F 655 | 1. R475 Has been discharged and is longer in facility; therefore, no corrective action can be initiated.<br><br>2. All current residents have Comprehensive Care Plans, no corrective action needed.<br><br>3. RCA: Nurse opened the Baseline Care Plan Assessment (BCP) on the day | |

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| F 655 | Continued From page 25<br>ten (10) day respite stay.<br><br>11/7/22 - A baseline care plan was developed for R475, five (5) days after admission to the facility.<br><br>1/9/23 at 5:45 PM - Findings were reviewed during the Exit Conference with E1 (NHA), E2 (DON), E3 (ADON) and E4 (AIT). | F 655 | of admission (11/4/2022, not 11/2/2022) which was a Friday afternoon. Nursing left sections unanswered for the Interdisciplinary Team (IDT) and locked on 11/6/2022. On Monday 11/7/2022, a new BCP Assessment was opened to allow IDT to complete their sections because they didn□t know how to unlock. There was no contingency for IDT input on Friday and Saturday admissions.<br><br>The Admission Director will discuss upcoming admissions each day at Clinical Rounds. For admissions on Friday/Saturday, the IDT will be required to make arrangements to ensure their sections will be completed timely. Additionally, it will be the expectation that all BCP Assessments are completed within 24 hours and the Nurse Manager on duty at that time will be responsible.<br><br>SDC or designee to educate IDT and Nurse Managers on updated process.<br><br>4. Director of Nursing or designee will conduct audits of new admissions daily x 3 to ensure the Baseline Care Plan is completed within 48 hours, until 100% compliance is achieved. Audits will continue weekly x 3, until 100% compliance is achieved. Audits will continue monthly x 2 until 100% compliance is achieved. Findings of the audits will be reported to the QAPI committee monthly x 3 months to ensure compliance is obtained and maintained. | |
| F 657 SS=D | Care Plan Timing and Revision | F 657 | | 3/10/23 |

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| F 657 | Continued From page 26<br>CFR(s): 483.21(b)(2)(i)-(iii)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(2) A comprehensive care plan must be-<br>(i) Developed within 7 days after completion of the comprehensive assessment.<br>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--<br>(A) The attending physician.<br>(B) A registered nurse with responsibility for the resident.<br>(C) A nurse aide with responsibility for the resident.<br>(D) A member of food and nutrition services staff.<br>(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.<br>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.<br>(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and interview, it was determined that for one (R477) out of twenty-four sampled residents, the facility failed to review and revise R477's care plan after a documented functional decline in ADL (Activity of Daily Living) tasks for bed mobility, transfer, eating, walking and locomotion (directional movement from one location to another). Findings include: | F 657 | 1. R477 is no longer at the facility and care plan cannot be corrected.<br><br>2. All residents with significant changes have potential to lack complete review and revision of functional status care plans. All significant changes since October 2022 were reviewed by LNAC | |

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| F 657 | Continued From page 27<br><br>Review of R477's closed clinical record revealed the following:<br><br>7/12/21 - R477 was admitted to the facility.<br><br>A review of R477's careplan revealed that on 7/12/21 (revised 11/23/21), R477 was care planned for an ADL self - care performance deficit related to dementia...and loss of balance at times. R477's interventions included independent to set up assistance of one staff member for bed mobility...and limited assist of one staff if she is tired for transfer. R477 was also independent with set up assist of one staff member for eating and required supervision of one person for locomotion on and off the unit, and walking in her room/corridor.<br><br>1/25/22 - R477 was readmitted from the hospital status post a broken left hip.<br><br>1/31/22 - R477's Significant Change MDS (Minimum Data Set, a standardized assessment form used in nursing homes) assessment documented that R477 had short and long term memory problems with severely impaired cognition. R477's ADL functional status revealed that R477 required extensive assistance of two staff members with bed mobility and transfers. R477 did not walk in her room or walk in the corridor. R477 required extensive asistance of one staff member assist for eating and locomotion on and off the unit during the review period.<br><br>1/31/22 5:13 PM - A late entry Activities note by E17 (Activities Director) documented that R477, "...now uses a wheelchair for transport." | F 657 | and all care plans were up to date with functional status.<br><br>3. RCA: At the time of the Significant Change MDS there was only one RNAC, who completed the MDS but did not update the care plan with the declines and is no longer at the facility.<br>Since October 2022, the facility has employed another FTE to manage the workload. During a significant change the LNAC will update the care plan with all functional areas affected per a review of the most recent functional status documentation.<br><br>SDC or designee will educate RNAC/LNAC on updating care plans with each functional area affected by a significant change.<br><br>4. DON or designee will conduct audits of residents with significant change daily x 3 to ensure all functional areas are updated until 100% compliance is achieved. Audits will continue weekly x 3, until 100% compliance is achieved. Audits will continue monthly x 2 until 100% compliance is achieved. Findings of the audits will be reported to the QAPI committee monthly x 3 months to ensure compliance is obtained and maintained. | |

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| F 657 | Continued From page 28<br><br>3/16/22 12:41 PM - A nursing progress note documented, "...nurse fed her (R477)breakfast...she only ate super cereal at lunch...was given a puree diet...after monitoring her (sic) she had to be fed and she ate 100% without difficulty."<br><br>The facility failed to review and revise R477's careplan to reflect her functional decline in mobility and eating ADLs.<br><br>1/6/23 5:15 PM - Findings were discussed with E2 (DON).<br><br>1/9/22 at 5:45 PM - Findings were reviewed during the Exit Conference with E1 (NHA), E2, E3 (ADON) and E4 (AIT). | F 657 | | |
| F 684 SS=D | Quality of Care<br>CFR(s): 483.25<br><br>§ 483.25 Quality of care<br>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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and interview, it was determined that for one (R476) out of one resident reviewed for death, the facility failed to ensure prompt emergency transportation after R476 experienced low oxygen levels and was observed with facial drooping. R476 was not | F 684 | 1. R476 is no longer a resident<br><br>2. No other residents identified<br><br>3. RCA: The root cause analysis determined there was a lack of accurate | 3/10/23 |

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| F 684 | Continued From page 29<br>transported for emergency care until several hours later. Findings include:<br><br>Cross refer F580<br><br>Review of National Institutes of Health webpage indicated, "Oxygen saturation levels around 96% to 100% are considered normal. "https://www.ncbi.nlm.nih.gov/books/NBK470348.<br><br>Review of R476's clinical record revealed:<br><br>8/1/17 - R476 was admitted to the facility.<br><br>8/2/17 - A Physicians order was written for R476 to be a DNR [do not resuscitate] RN may pronounce. R476's order did not include a do not hospitalize directive.<br><br>3/28/20 - A Physician's order was written for R476 to include, check temperature and pulse oxygen (oxygen saturation) daily. If temperature is 100 degrees or greater or if there is any abnormal low temperature and pulse oxygen report to Physician immediately.<br><br>10/21/21- A quarterly MDS assessment documented R476 was cognitively (mentally) impaired.<br><br>11/14/21 12:56 PM - E11 (LPN) documented in an order administration note in R476's clinical record that R476 received an "Albuterol nebulizer breathing treatment and that prior to the treatment the resident had vitals of 88% oxygen saturation on room air." The clinical record lacked evidence that a Physician was notified of R476's low oxygen saturation. | F 684 | documentation of actions taken during this deficiency, which would have explained the identified delay in emergency care. Through interview of E11 and E21, it was determined their actions to care for the resident were done properly, but these actions were not documented accurately, if at all, in R476□s record. The lack of documentation made it appear that R476□s facial droop happened at 1500. During an interview with E11, the facial droop symptoms actually did not begin until 1630. Once the Nursing Supervisor fully assessed R476, E11 immediately paged the On-call Provider for an order to send R476 out to the hospital. This occurred at approximately 1640. When the on-call provider did not call back within 15 minutes,, the Nursing supervisor placed another page to the answering service. The Provider called back 16 minutes later at 1711. After receiving the provider□s order to send R476 to the hospital, the Nursing Supervisor immediately called 911, at approximately 1715. EMS and ALS arrived within 10 minutes, and the resident left the building at 1739 per E11.<br><br>During weekday daily Clinical Rounds, all resident transfers from the previous day will be discussed, and documentation reviewed for timeliness of care. If follow-up is needed, the Unit Manager or their designee will interview the licensed personnel to clarify the event timeline. If the record is felt to be incomplete, the nursing staff will clarify the documentation via a Late Note. | |

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| F 684 | Continued From page 30<br>11/14/21 3:58 PM - E11 (LPN) documented in an orders administration note in R476's clinical record that R476 received an Albuterol nebulizer breathing treatment and that prior to the treatment the resident had vitals of 86% oxygen saturation on room air."The clinical record lacked evidence that a Physician was notified of R476's low oxygen saturation.<br><br>11/14/21 4:30 PM - E21 (RN) documented in a nurses note in R476's clinical record, "Late Entry: Note Text: Call placed to E5's (MD) on-call service, received return call from E22 (MD). This RN informed E22 of resident's hypoxia [low oxygen level], increased 02[oxygen] requirements, fever, increased congestion, facial droop and change in neurological base-line... Resident will be transferred out to the hospital emergency room for higher level of care and further evaluation. Residents Daughter and Primary Nurse at bedside."<br><br>11/14/21 5:10 PM - E22 (MD) note documented in R476's clinical record, "Received message from oncall RN stating concern about patient's respiratory status. Per RN, patient developed increased congestion/cough early last week... new right sided facial droop. RN requesting recommendations for next steps....Temperature: 101.8 F. Per RN, patient with decreased breath sounds on the left lower lung and coarse breath sounds throughout on exam. Patient with new right sided facial droop that started this afternoon about an hour before discussion. Discussed with RN that patient should proceed to ED for further evaluation to rule out pneumonia."<br><br>11/14/21 5:16 PM - E21 documented on an interagency form, "E5 (MD) notified 5:15 PM, RP1 | F 684 | The SDC, or their designee, will educate all licensed staff.<br><br>4. The DON or their designee will conduct audits of changes in resident status, as noted on the Supervisor□s 24 hour report sheet, daily x 3 to ensure that timeliness of care occurred until 100% compliance is achieved. Audits will continue weekly x 3, until 100% compliance is achieved. Audits will continue monthly x 2 until 100% compliance is achieved. Findings of the audits will be reported to the QAPI committee monthly x 3 months to ensure compliance is obtained and maintained. | |

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| F 684 | Continued From page 31<br>5:16 PM Reason for transfer: Fever, increased congestion, hypoxia, increased 02 requirements, decreased mentation and right facial droop. [temperature]101.8...".<br><br>11/14/21 6:32 PM - E11 (LPN) documented in a nurses note in R476's clinical record, "Late Entry: Note Text: During 3:00 PM rounds this writer continued the assessment. Resident had 100.1 (tempature); 86% O2 on room air. Resident was placed on 2 liters of oxygen treatment effective; resident raised to 93% oxygen saturation. Crackles were present at this time. Albuterol sulfate nebulizer [breathing treatment] was administered. Treatment ineffective. Resident continued to have trouble with coughing up phlegm. Began to grimace when coughing. Right side facial droop was present. Supervisor did assessment. RP1 was immediately notified of residents condition. Daughter was asked if she would like her mother to go to the hospital she replied 'yes'. Daughter arrived to facility shortly after. Resident was continuously assessed until paramedics arrived."<br><br>11/14/21 6:19 PM -The hospital emergency department record for R476 documented, "Prior to hospital arrival patient comes from nursing facility after they noted her to have a new onset right-sided facial droop approximately three hours prior to hospital arrival."<br><br>R476's clinical record revealed low oxygen saturation at 12:56 PM and change in neurological status, facial drooping during 3:00 PM rounds. R476 was not transported to the hospital until some time after 5:16 PM, greater than two hours after changes were documented as assessed by E11 (LPN). | F 684 | | |

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| F 684 | Continued From page 32<br><br>During an interview on 1/5/23 at 1:21 PM with RP1 it was reported that, "She [R476] wasn't doing well and I left around noon that day and I had told her [E11 LPN] I was pissed and they decided to send her to the ER. I waited an hour they still hadn't done it as I was walking in they had just gotten on the phone for the MD order, they sent her to the ER as a stroke alert." RP1 stated the ambulance arrived, "I wanna say around 6:00 PM" and the delay in R476's emergency transport was because, "They said they were waiting to hear from the doctor or the doctors order. I was talking with E11 and she was very vocal about how it was taking a long time to get the order."<br><br>During an interview on 1/6/23 at 4:34 PM, E1 (NHA) stated that delays in emergency transportation of residents is "Sometimes a matter of contacting the Doctor and waiting to get a call back. If they've not heard back from the Doctor, they should call again and if still no response text them directly. We would call 911 and send them out." When asked what the expected timeframe was to send a Resident out with stroke symptoms such as facial drooping, E1 responded, "... 20 - 30 minutes, I would call 911."<br><br>During an interview on 1/9/23 at 4:29 PM, E11 (LPN) confirmed that she did not immediately call for emergency services after noticing facial drooping of R476 during an assessment. E11 stated, "I informed my Supervisor [E21 RN] first, then the Supervisor notified the Doctor while I stayed in the residents room."<br><br>During an interview on 1/9/23 at 9:16 AM, E21 (RN) stated,"I sent her [R476] out at change of | F 684 | | |

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| F 684 | Continued From page 33<br>shift, it was 3-11. The evening Nurse went to assess the resident then she notified me R476 wasn't doing well, low oxygen saturation, increased work of breathing, and facial droop. We were doing nebulizer's and oxygen I talked to the doctor and we called the daughter to verify she wanted R476 to go to the hospital. E21 stated, "I was notified around 4:00 that R476 had a change and then time to assess, call the doctor and get a response. Once I'd spoken to the doctor and RP1 I called the ambulance and they were there quickly."<br><br>1/9/22 at 5:45 PM - Findings were reviewed during the Exit Conference with E1 (NHA), E2 (DON), E3 (ADON) and E4 (AIT). | F 684 | | |
| F 756 SS=D | Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5)<br><br>§483.45(c) Drug Regimen Review.<br>§483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.<br><br>§483.45(c)(2) This review must include a review of the resident's medical chart.<br><br>§483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon.<br>(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.<br>(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 | F 756 | | 3/10/23 |

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| F 756 | Continued From page 34<br>director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.<br>(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.<br><br>§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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record reviews and interviews, it was determined that for two (R30 and R58) out of five residents sampled for unnecessary medication review, the facility failed to consistently act on the irregularities/pharmacy recommendations that were identified by the Pharmacist during medication regimen reviews (MRRs). Findings include:<br><br>1. Review of R30's medical record revealed:<br><br>1/6/23 - R30's record review lacked evidence of a recent MRR.<br><br>1/6/23 1:08 PM - During a phone interview with C1 (Pharmacy Consultant) regarding MMRs, C1 discussed the recent MRR (dated 11/20/22) for R30. C1 sent the Surveyor an email with a MMR from 11/20/22, which identified two | F 756 | 1. The original Medication Regimen Reviews (MRRs) dated 11/22/2022 for R30 and R58 were reviewed and by the Provider on 2/2/2023. Many of the recommendations were addressed per a review of orders. Other updates were made as necessary, and the completed forms scanned into the medical record on 2/3/2023.<br><br>2. All residents with MRRs have potential to be affected. All MRRs back to November 2022 were audited, the Provider updated any that were not already completed on 2/2/2023. All copies to be scanned to the medical record on 2/3/2023.<br><br>3. RCA: The Pharmacy Consultant | |

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| F 756 | Continued From page 35<br>recommendations for Physician review that requested clarifications of the need for two antidepressant medications and the antianxiety medication order.<br><br>1/9/23 10:50 AM - During an interview with E3 (ADON) regarding R30's MMR documentation with Physician/provider responses, E3 admitted to being unable to locate the MMR with the Physician response in R30's medical record. E3 stated, "We need a better system."<br><br>2. Review of R58's medical record revealed:<br><br>1/6/23 - R58's record review lacked evidence of a recent MMR.<br><br>1/6/23 1:08 PM - During a phone interview with C1 (PC) regarding MMRs, C1 discussed the MRR for R58 ( dated 11/20/22) and provided the Surveyor with a copy via email. The MMR identified three recommendations for Physician review: the length of therapy for an antibiotic, clarification of a diagnosis for an antipsychotic medication and review of risk/benefit to R58 for a medication for overactive bladder.<br><br>1/9/23 10:50 AM - During an interview with E3 (ADON) regarding R58's MMR documentation with Physician/provider responses, E3 stated she was unable to locate R58's MMR documents in the medical record. E3 stated, "We need a better system."<br><br>1/9/23 at 5:45 PM - Findings were reviewed during the Exit Conference with E1 (NHA), E2 (DON), E3 (ADON) and E4 (AIT). | F 756 | emailed the MRR to nursing, who then printed them and placed in the provider binder for review. The provider was then placing the completed forms in a bin with many other papers. Additionally, it was found that the provider was writing responses to the recommendations on the papers, and not entering in order changes herself. This was discussed with the provider who agreed to enter the orders into the EHR at the time of the review moving forward.<br><br>The Pharmacy Consultant will email the MRR to the provider, as well as nursing. The provider will print the forms, complete, and update PCC orders as necessary. The provider will hand deliver the forms to the Nurse Management on duty. The Nurse Management will verify completion, confirm orders in PCC, and scan forms into resident□s chart in PCC. The forms will then be given to the ADON, who will check them against the original email from the consultant to ensure accuracy and they appear in the residents□ charts.<br><br>SDC or designee will educate Nurse Management on the updated process and their responsibility to ensure all changes are made to the resident□s EHR and a copy scanned into the Miscellaneous section of the resident□s EHR.<br><br>4. The ADON, or designee, will conduct audits of all MRR reports monthly x 3 to ensure all are addressed and scanned until 100% compliance is achieved. | |

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| F 756 | Continued From page 36 | F 756 | Findings of the audits will be reported to the QAPI committee monthly x 3 months to ensure compliance is obtained and maintained. | |
| F 758 SS=D | Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5)<br><br>§483.45(e) Psychotropic Drugs.<br>§483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:<br>(i) Anti-psychotic;<br>(ii) Anti-depressant;<br>(iii) Anti-anxiety; and<br>(iv) Hypnotic<br><br>Based on a comprehensive assessment of a resident, the facility must ensure that---<br><br>§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;<br><br>§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;<br><br>§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and | F 758 | | 3/10/23 |

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| F 758 | Continued From page 37<br><br>§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.<br><br>§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, interviews and review of facility documentation, it was determined that for one (R58) out of five residents reviewed for unnecessary medications, the facility used a psychotropic medication in the absence of an indication for use, behavior monitoring and side effect monitoring. Findings include:<br><br>Risperdal is approved by the Federal Drug Administration (FDA) as an atypical anti-psychotic medication that is used to treat certain mental disorders including schizophrenia, acute mania or mixed episodes associated with bipolar disorder and irritability associated with autistic disorder. (Source- published by Ortho-McNeil-Janssen Pharmaceuticals, Inc, revised July 2009)<br><br>Review of R58's medical record revealed:<br><br>11/3/22 - The hospital's Admission History & Physical documented a diagnosis of auditory hallucinations. | F 758 | 1. Resident R58□s psychotropic medication orders were reviewed, and resident diagnoses corrected for the medication prescribed. Orders for behavior monitoring, with tasks attached, were applied to the medication order, Behavior monitoring order placed, and side effect monitoring order placed. The behavior monitoring task was added to the POC CNA tasks.<br><br>2. All residents with psychotropic medications have the potential to be affected. Residents on psychotropics were audited and corrections were made, as needed to the diagnosis and/or monitoring. Completed on 2/2/2023 by NHA.<br><br>3. RCA: Providers were not updating their orders to reflect the reason for the psychotropic medication. Also, when the | |

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| F 758 | Continued From page 38<br><br>12/1/22 - R58's Initial Psychiatric Assessment dated 12/01/22 by E13 (Psych NP) documented a plan to "D/C (discontinue) risperidone (Risperdal)... Continue to monitor mood and behavior. Will follow up as needed." This recommendation was not written as an order and R58 continued on Risperdal without any attempt to discontinue the drug.<br><br>There was no evidence that the facility or E13 identified what mood and behavior symptoms needed to be monitored.<br><br>1/5/23 at approximately 4:00 PM- R58's current orders in the EMR (electronic medical record) revealed an order for Risperdal for depression.<br><br>1/6/23 1:08 PM- During a phone interview C1 (CP) discussed a recent MRR (medication regimen review) from 11/20/22 requesting clarification for a diagnosis for Risperdal. The facility lacked evidence that the Risperdal order was clarified by a Physician/provider.<br><br>The physician order for Risperdal continued to be depression which is not a diagnosis that supports the use of the anti-psychotic medication Risperdal.<br><br>1/6/23 2:17 PM - During an interview, E12 (RN) stated that Nurses were prompted each shift in the MAR to document behaviors but noted that the order does not give examples of behaviors the resident may exhibit. E12 stated that Nurses were prompted each shift in the MAR to assess the resident's response and adverse reactions to the medication as well. E12 stated that the only manner that staff are alerted to the fact that a | F 758 | facility contracted with a different Pharmacy in the Fall, the PCC order for the behavior monitors were accidently discontinued.<br>The PCC order for behavior monitoring has been corrected. A checklist will be utilized to ensure all components of the Psychotropic orders are checked and correct. Residents with new psychotropic medications and reviewed with the Psych provider monthly.<br><br>SDC or designee will provide education to all licensed staff on proper diagnosis and monitoring, including the proper use of the new updated monitoring order.<br><br>4. The ADON, or their designee, will conduct audits of residents with psychotropic orders daily x 3 to ensure accurate diagnosis and monitoring, until 100% compliance is achieved. Audits will continue weekly x 3, until 100% compliance is achieved. Audits will then continue monthly x 2 until 100% compliance is achieved. Findings of the audits will be reported to the QAPI committee monthly x 3 months to ensure compliance is obtained and maintained. | |

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| F 758 | Continued From page 39 | F 758 | | |

resident is on psychotrophic medicines comes via the MAR and staff-to-staff report. E12 also stated that there was a Behavior Book on the 500 hallway in which staff can document resident behaviors and the off-shift supervisors check the book daily to monitor the behaviors.

During the same interview, E12 stated that R58's behaviors were anxiety, sadness, being tearful and crying when staff would leave at the end of the shift, especially when she was first admitted in November. E12 did not recall R58 calling out inappropriately or aggressive/ bizarre behaviors since she was admitted. When asked about documenting R58's behaviors, E12 stated, "It is in the MAR", but when E12 went to the MAR/TAR in the EMR to show the Surveyor, E12 stated, "There is usually an order to monitor behaviors but R58 does not have one."

1/6/23 at approximately 4:00 PM - Review of R58's monthly (November, December and January) MAR and TAR revealed no order to document targeted behaviors (calling out, auditory hallucinations) or adverse side effects to the Risperdal.

Review of R58's monthly (December, January- no page for November) pages in the Behavior Book on the 500 hallway revealed that the staff were monitoring for "Behavior: Potential safety hazard as self evidenced by unsafe transfers/unassisted transfers."

The facility failed to identify and monitor R58's targeted behaviors that were being treated by Risperdal.

1/9/23 at 5:45 PM - Findings were reviewed

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| F 758 | Continued From page 40<br>during the Exit Conference with E1 (NHA), E2 (DON), E3 (ADON) and E4 (AIT). | F 758 | | |
| F 812 SS=F | Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)<br><br>§483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and interview, it was determined that the facility failed to routinely monitor food temperatures for 14 out of 122 meals reviewed. Findings include:<br><br>The facility policy on food preparation, last updated September 2017, indicated, "Temperature for time/temperature control for safety foods will be recorded at time of service, and monitored periodically during meal service periods." | F 812 | 1. No resident identified.<br><br>2. No other residents potentially affected.<br><br>3. RCA: The Log to record the temperatures monitored at the time of meal service contained small boxes that were difficult to fill in quickly. The Log was kept in the Culinary office and staff were to record the temperatures they monitored at the conclusion of the meal. At times staff got busy with other tasks | 3/10/23 |

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| F 812 | Continued From page 41<br>1/3/23 12:33 PM - Review of the facility food temperature logs revealed a total of fourteen (14) meals served between September 1, 2022 through December 31, 2022 without recorded food temperatures.<br><br>During an interview on 1/3/23 at 2:19 PM, E29 (FSD) confirmed the findings.<br><br>1/9/22 at 5:45 PM - Findings were reviewed during the Exit Conference with E1 (NHA), E2 (DON), E3 (ADON) and E4 (AIT). | F 812 | and forgot to fill in the log.<br><br>A new Log sheet was created that has bigger boxes that will be easier to fill in quickly. The Log will be hanging on the wall by the food service line in the view of the cook, be completed by Cooks and AFSD before meal service starts. The Logs will be turned into the FSD for review, clarified if necessary and stored in a master binder in the FSD office.<br><br>4. FSD or designee, audit temperature logs daily x 3 days to ensure completion until100% compliance is achieved. Audits will continue weekly x 3 weeks until 100% compliance is achieved. Audits will continue monthly x 2 until 100% compliance is achieved. Findings of the audits will be reported to the QAPI committee monthly x 3 months to ensure compliance is obtained and maintained. | |
| F 851 SS=C | Payroll Based Journal<br>CFR(s): 483.70(q)(1)-(5)<br><br>§483.70(q) Mandatory submission of staffing information based on payroll data in a uniform format.<br>Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS.<br><br>§483.70(q)(1) Direct Care Staff.<br>Direct Care Staff are those individuals who, | F 851 | | 3/10/23 |

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| F 851 | Continued From page 42<br>through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping).<br><br>§483.70(q)(2) Submission requirements.<br>The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following:<br>(i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS);<br>(ii) Resident census data; and<br>(iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual).<br><br>§483.70(q)(3) Distinguishing employee from agency and contract staff.<br>When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency.<br><br>§483.70(q)(4) Data format.<br>The facility must submit direct care staffing information in the uniform format specified by | F 851 | | |

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| F 851 | Continued From page 43<br>CMS.<br><br>§483.70(q)(5) Submission schedule.<br>The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview it was determined that the facility failed to electronically submit the payroll based journal data for the 4th quarter of 2022. Findings include:<br><br>1/6/22 12:09 PM - During an interview with E1 (NHA) it was confirmed that the electronic data for the 4th quarter payroll based journal was not submitted by the deadline.<br><br>1/9/23 5:45 PM - Findings were reviewed during the Exit Conference with E1 (NHA), E2 (DON), E3 (ADON) and E4 (AIT). | F 851 | 1. No residents identified<br><br>2. No residents identified<br><br>3. RCA: The New Payroll manager and HR Director not informed of PBJ reporting requirements by previous employees during their orientation process, nor instructed on process for reporting.<br><br>HR Director, Payroll Manager, and CEO met with an outside contractor, viewed demo of electronic software to file PBJ reports for the facility. Training by Simple, a Netsmart solution, on utilizing the SimplePBJ software and filing reports, was held on 2/3/2023.<br><br>4. HR Director, or their Designee, will audit to ensure the PBJ report is accepted by CMS within 2 business days of close of pay each pay period x 3 until 100% compliance is achieved. Audits will continue monthly x 3 until 100% compliance is achieved. Findings of the audits will be reported to the QAPI committee monthly x 6 months to ensure compliance is obtained and maintained. | |
| F 867 SS=F | QAPI/QAA Improvement Activities<br>CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) | F 867 | | 3/10/23 |

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| F 867 | Continued From page 44<br><br>§483.75(c) Program feedback, data systems and monitoring.<br>A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following:<br><br>§483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement.<br><br>§483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators.<br><br>§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.<br><br>§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. | F 867 | | |

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| F 867 | Continued From page 45<br><br>§483.75(d) Program systematic analysis and systemic action.<br><br>§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.<br><br>§483.75(d)(2) The facility will develop and implement policies addressing:<br>(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;<br>(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and<br>(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.<br><br>§483.75(e) Program activities.<br><br>§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.<br><br>§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the | F 867 | | |

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| F 867 | Continued From page 46<br>facility.<br><br>§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e).<br>Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.<br><br>§483.75(g) Quality assessment and assurance.<br><br>§483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:<br><br>(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;<br>(iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview, review of facility documentation and a finding during the current survey, it was determined that during the year 2022, the facility failed to utilize the Quality Assurance and Performance Improvement | F 867 | 1. No specific residents identified.<br><br>2. No other residents potentially affected.<br><br>3. RCA: The COVID-19 Omicron surge | |

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| F 867 | Continued From page 47<br>(QAPI) program to identify, analyze, develop and implement action plans to correct areas that impacted quality of care, quality of life, and resident safety. Findings include:<br><br>Cross refer to F868 and F881<br><br>1/5/23 at 6:00 PM - During a combined interview, E1 (NHA) and E4 (AIT) stated that the facility had not been keeping up with their QAPI program. E1 stated that they identified the problem one month ago and have initiated a performance improvement plan (PIP) on QAPI.<br><br>The facility's document entitled "QAPI on QAPI" stated, "Effective December 9, a 'rebirth' of the Kutz Senior Living Campus (KSLC) QAPI program began. The first step was to engage a QAPI consultant to help define the actionable plan and implementation of the KSLC program, including all new guidance from CMS, with the expectation of full implementation of the plan to occur no later than March 31, 2023... Members of the KSLC Interdisciplinary Team will serve as our in-house members will meet the first week of each month, commencing January 4, 2023. Vendors and consulting organizations will begin to meet quarterly, commencing January 4, 2023...".<br><br>An example of an area where the facility's QAPI program failed to be utilized during the year 2022 was the lack of an ongoing review of antibiotic stewardship as part of their Infection Control and Prevention Program.<br><br>1/9/23 at 5:45 PM - Findings were reviewed during the Exit Conference with E1, E2 (DON), E3 (ADON) and E4 (AIT). | F 867 | started in December 2021, putting an increased pressure on already stressed staffing resources. The entire industry has been struck with unprecedented staffing challenges with seasoned staff leaving related to burnout and few available candidates to replace them. Kutz Senior Living Campus (KSLC) has not been immune to this trend and has done their best to keep residents well cared for without the luxury of time and resources to devote to formally document the hard work they did correcting all issues they identified and corrected.<br><br>Effective December 9, a 'rebirth' of the KSLC QAPI program began. The first step was to engage a QAPI Consultant to help define the actionable plan and implementation of the KSLC program, with the expectation of full implementation of the plan to occur no later than March 31, 2023.. QAPI Consultant began meeting with the IDT weekly on January 4th, 2023 to provide an 8 week, in-depth education on QAPI.<br><br>4. KSLC Nursing Home Administrator or designee will conduct audits of the monthly QAPI minutes x 3 to ensure that action plans are implemented, until 100% compliance is achieved. Findings of the audits will be reported to the QAPI committee to ensure compliance is obtained and maintained. | |

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| F 868 | Continued From page 48 | F 868 | | |
| F 868 SS=F | QAA Committee<br>CFR(s): 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c)<br><br>§483.75(g) Quality assessment and assurance.<br>§483.75(g) Quality assessment and assurance.<br>§483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of:<br>(i) The director of nursing services;<br>(ii) The Medical Director or his/her designee;<br>(iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and<br>(iv) The infection preventionist.<br><br>§483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:<br>(i) Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects required under the QAPI program, are necessary.<br><br>§483.80(c) Infection preventionist participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. | F 868 | | 3/10/23 |

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| | 085043 | A. BUILDING _____ B. WING _____ | C 01/09/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| KUTZ REHABILITATION AND NURSING | 704 RIVER ROAD WILMINGTON, DE 19809 |

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| F 868 | Continued From page 49<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and review of facility documentation, it was determined that the facility's quality assurance committee failed to meet at least quarterly. Findings include:<br><br>Facility documentation revealed that the last quarterly QAPI (Quality Assurance and Performance Improvement) meeting was held on 10/28/21. The facility held the next QAPI meeting on 1/4/23. The facility's QAPI committee failed to meet quarterly during the year 2022.<br><br>During a combined interview, E1 (NHA) and E4 (AIT) confirmed the finding.<br><br>1/9/23 at 5:45 PM - Findings were reviewed during the Exit Conference with E1 (NHA), E2 (DON), E3 (ADON) and E4 (AIT). | F 868 | 1. No specific residents identified.<br><br>2. No other residents potentially affected.<br><br>3. RCA: The COVID-19 Omicron surge started in December 2021, putting an increased pressure on already stressed staffing resources. The entire industry has been struck with unprecedented staffing challenges with seasoned staff leaving related to burnout and few available candidates to replace them. Kutz Senior Living Campus (KSLC) has not been immune to this trend and has done their best to keep residents well cared for without the luxury of time and resources to devote to formally document the hard work they did correcting all issues they identified and corrected.<br><br>Effective December 9, a 'rebirth' of the KSLC QAPI program began. The first step was to engage a QAPI Consultant to help define the actionable plan and implementation of the QAPI program, with the expectation of full implementation of the plan to occur no later than March 31, 2023. Members of the Interdisciplinary Team (IDT) serving as in-house members, vendors and consulting organizations began to meet quarterly, commencing January 4, 2023.<br><br>QAPI Consultant began meeting with the IDT weekly on January 4th, 2023 to provide an 8 week, in-depth education on QAPI. | |

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| F 868 | Continued From page 50 | F 868 | 4. KSLC Nursing Home Administrator will conduct audits of the Monthly and Quarterly Quality Assurance Committee minutes x 3 to ensure the QAA Committee meets at least monthly and the IDT QAPI team meets at least quarterly x2 until 100% compliance is achieved. Findings of the audits will be reported at the quarterly QAPI meetings and to the KSLC Board of Directors QA Committee x 2, to ensure compliance is obtained and maintained. The first meeting already occurred on January 4th, 2023 and reported to the full Board of Directors on January 26, 2023. | |
| F 881 SS=C | Antibiotic Stewardship Program<br>CFR(s): 483.80(a)(3)<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use.<br>This REQUIREMENT is not met as evidenced by:<br>Based on policy review, record review and interview, it was determined that the facility failed to conduct an ongoing review of antibiotic stewardship. Findings include:<br><br>Review of the undated facility Antibiotic Stewardship policy revealed, #1: "Antibiotic stewardship is part of our infection prevention | F 881 | 1. The urine culture for R58 was in the miscellaneous file as it was part of her admission on 11/09/2023. The urine culture was not ordered or resulted in the facility. | 3/10/23 |

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| F 881 | Continued From page 51<br>program.<br><br>Review of the 12/2022 revised facility Infection Control Program policy revealed: "The Infection Prevention and Control Officer responsibilities include: The nursing staff maintains the 24-hour report which lists the residents on antibiotics. The Infection Prevention and Control Officer reviews the report and collects nosocomial, and community acquired infection data via medication review, nursing documentation and laboratory reports."<br><br>11/9/22 - EMR Physician Current Order for R58: Methenamine Hippurate 1 Gram by mouth two times a day for urinary tract infection. A urine culture result is not present in the EMR.<br><br>1/5/23 2:14 PM - During an interview, E3 (Infection Preventionist) stated that she tracks residents who are taking antibiotics on an undefined schedule, sometimes on a weekly basis, and sometimes only on a monthly basis.<br><br>1/9/23 at 5:45 PM- Findings were reviewed during the Exit Conference with E1 (NHA), E2 (DON), E3 (ADON) and E4 (AIT). | F 881 | 2. All residents had the potential to be affected by the deficient practice<br>E3 reviewed all residents currently on ABT on 01/13/2023 for infection and added to line list<br><br>3. RCA: During COVID pandemic, the line list was almost exclusively related to COVID. The demands of tracking COVID outbreaks were the primary focus to ensure resident safety. The few infections that have occurred or been admitted were not up to date on a proper line list.<br><br>NHA educated IPOC on use of Line list for all infections other than COVID.<br><br>4. IPCO or designee will conduct audits of residents on ABT daily x 3 to ensure it was added to line list until 100% compliance is achieved. Audits will continue weekly x 3, until 100% compliance is achieved. Audits will continue monthly x 2 until 100% compliance is achieved. Findings of the audits will be reported to the QAPI committee monthly x 3 months to ensure compliance is obtained and maintained. | |
| F 943 SS=E | Abuse, Neglect, and Exploitation Training<br>CFR(s): 483.95(c)(1)-(3)<br><br>§483.95(c) Abuse, neglect, and exploitation.<br>In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, | F 943 | | 3/10/23 |

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| F 943 | Continued From page 52<br>facilities must also provide training to their staff that at a minimum educates staff on-<br><br>§483.95(c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12.<br><br>§483.95(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property<br><br>§483.95(c)(3) Dementia management and resident abuse prevention.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and review of facility documentation as indicated, it was determined that the facility failed to ensure that the required training on abuse, neglect and exploitation was completed for five (E31, E32, E33, E34 and E35) out of nine randomly sampled staff members. Findings include:<br><br>Review of facility submitted records revealed:<br><br>7/14/22 - The first day of assignment at the facility for E35 (LPN).<br><br>11/28/22 - The first day of assignment at the facility for E32 (Admission Director).<br><br>12/5/22 - The first day of assignment at the facility for E34 (RN).<br><br>12/20/22 - The first day of assignment at the facility for E33 (Maintenance Director).<br><br>1/2/23 - The first day of assignment at the facility for E31 (CNA). | F 943 | 1. Abuse training will be provided to E31, E32, E33, E34 and E35 by February 15, 2023.<br><br>2. All staff hired since 7/1/2022 have the potential to be affected. All staff without abuse training will be provided by training by 2/15/2023.<br><br>3. RCA: This training was previously being performed at New Employee Orientation. The Orientation Days had been cancelled at times.<br><br>New employees are now assigned Abuse trainings on-line by the Human Resources (HR) Department, to be completed prior to their first assignment. The new employee is compensated for the time they are completing these webinars. The Nursing Scheduler confirms in the nursing education electronic system that the education has been completed prior to their first floor orientation day. | |

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| F 943 | Continued From page 53<br><br>1/6/22 5:21 PM - During an interview, E1 (NHA) confirmed that the above employees had not received abuse, neglect and exploitation training.<br><br>1/9/23 5:45 PM- Findings were reviewed during the Exit Conference with E1, E2 (DON), E3 (ADON) and E4 (AIT). | F 943 | Nursing Home Administrator educated HR on the new process on 2/2/2023.<br><br>4. HR (or designee) will conduct audits of new hire training weekly 3 until 100% compliance is achieved. Audits will continue monthly x 2 until 100% compliance is achieved. Findings of the audits will be reported to the QAPI committee monthly x 3 months to ensure compliance is obtained and maintained. | |