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: Shipley Living Health Care Nursing Home **DATE SURVEY COMPLETED:** January 26, 2023

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced Annual and Complaint was conducted at this facility from January 19, 2023 to January 26, 2023. During this period an Emergency Preparedness Survey was also conducted by the State of Delaware's Division of Health Care Quality Long Term Care Residents Protection in accordance with 42 CFR 483.73. The facility census the first day of the survey was 47. The survey sample totaled 14 residents.		
3201	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.0	**Scope**		
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** This requirement is not met as evidenced by: Cross Refer to the CMS 2567-L survey completed 1/26/2023: F550, F578, F580, F623, F646, F655, F656, F657, F677, F684, F732, F756, F757, F761, F812, F868, F880, F881, F882, F885, F886, F943.	The community acknowledges the receipt of both the State Survey report and the 2567 report, dated 01/26/2023 for the annual survey inspection results, including the following tag numbers: F550F578, F580, F646, F655, F657, F677, F684, F684, F732, F732, F756, F757, F761, F812, F868, F880, F881, F882, F885, F886, F943	

Provider's Signature [signature] Title Executive Director Date 2/09/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085031	A. BUILDING ____ B. WING ____	C 01/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHIPLEY LIVING	2723 SHIPLEY ROAD WILMINGTON, DE 19810

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E 000	Initial Comments An unannounced Annual and Complaint Survey was conducted at this facility from January 19, 2023 through January 26, 2023. The facility census the first day of the survey was 47. During this period an Emergency Preparedness Survey was also conducted by the State of Delaware's Division of Health Care Quality Long Term Care Residents Protection in accordance with 42 CFR 483.73. For the Emergency Preparedness survey, no deficiencies were cited.	E 000		
F 000	INITIAL COMMENTS An unannounced Annual and Complaint Survey was conducted at this facility beginning January 19, 2023 and ending January 26, 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 first day of the survey was 47 residents. The investigative sample totaled 14. Abbreviations/definitions used in this report are as follows: ADL - Activities of Daily Living; ADON - Assistant Director of Nursing; Advanced Directive - a written statement of a person's wishes regarding medical treatment, often including a living will, made to ensure those wishes are carried out should the person be unable to communicate them to a doctor; C. difficile - bacterial overgrowth that releases toxins that attack the lining of the intestines; CNA - Certified Nursing Assistant;	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 02/14/2023

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 CrCl - Creatinine Clearance; DHSS - Department of Health and Social Services; DNR - Do Not Resuscitate; DON - Director of Nursing; Erythema - Redness; HS - Hour of Sleep or bedtime; IDT - Interdisciplinary Team; LPN - Licensed Practical Nurse; MASD - Moisture Associated Skin Damage; MDS (Minimum Data Set) - a standardized set of assessments completed in nursing homes; MRR - Medication Regimen Review; NHA - Nursing Home Administrator; NP - Nurse Practitioner; Ombudsman - resident representative who investigates reported complaints and helps to achieve agreement between parties; Pathogens - microorganisms capable of producing disease; POA - Power of Attorney; RN - Registered Nurse; r/t - related to; SW - Social Worker; ZN - Zinc, a skin protectant.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §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	F 550		3/2/23

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F 550	Continued From page 2 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. §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. §483.10(b) Exercise of Rights. 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. §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. §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. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined for one (R15) out of 47 residents reviewed for dignity, the facility failed to protect and value R15's private space when staff entered the residents room without requesting permission. Findings include: 1/19/23 9:37 AM - During the initial pool interview	F 550	Corrective Action: " Corrective actions have been ensured by the Director of Nursing. Resident R15 has been provided an updated copy of the Residents Rights and informed of their right to privacy. The resident has been informed of the expectation that staff will knock and request entry before entering	

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F 550	Continued From page 3 R15 was asked about any privacy and dignity concerns and R15 stated, "Fifty percent of the time when I'm being changed I have to ask them to close the door." 1/20/23 1:43 PM - R15's door was closed with staff present in the room. R15's call light was on. 1/20/23 1:45 PM - E18 (LPN) was observed entering R15's room without knocking and receiving permission to enter. E18 immediately confirmed the finding. 1/26/23 from 1:20 PM to 2:15 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (DON) and E19 (Regional Clinical Nurse Specialist).	F 550	the resident room, and that staff are expected to provide the resident privacy during care; the resident has been encouraged to notify the Director of Nursing if this does not take place. The care plan has been reviewed and updated to include the resident preference that staff request entry before entering the resident room. Identification of Other Residents: " All Residents have the potential to be affected. In order to prevent other residents from being affected, all staff will be trained on Residents Rights and the requirement to knock and request entry prior to entering a resident room. The nursing management team conducts daily rounds and since this concern was noted on survey they have focused on observing staff actions to ensure that staff knock before entering resident rooms; no new concerns have been identified during these observations. System Changes: " The Root Cause of the concern was the failure to accurately adhere to the required elements in the policy Residents Rights (revised 12.2016) and the policy for Dignity (rev. 2.2021). The facility policy for Residents Rights (revised 12.2016) and Dignity (rev. 2.2021) were reviewed and found to meet professional standards. The facility system for daily nursing management rounds (see IDT Rounds Form tool) has been updated to include a focus on ensuring that staff knock before entering a resident room. The Director of	

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F 550	Continued From page 4	F 550	Nursing or Designee will complete education for all staff on residents rights and dignity, including the requirements that staff knock and request entry before entering the resident room. The nursing management team will provide oversight to ensure ongoing compliance. Success Evaluation: " An audit of a random sample of a minimum of 10 staff and resident interactions will be observed to ensure that staff honor residents rights and treat residents with dignity, including knocking on the resident door and requesting entry; Audits will be completed by the Director of Nursing or Designee; Audits will have a goal of 100% compliance; Audits will be completed weekly until 100% compliance is achieved for 3 consecutive evaluations, then every other week until 100% compliance is achieved for 3 consecutive evaluations, and then monthly until 100% compliance is achieved for 3 consecutive evaluations. Additional audits will be completed as needed based upon the level of compliance. The results of the audits will be reviewed by the Quality Assurance Team.	
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §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. §483.10(c)(8) Nothing in this paragraph should be	F 578		3/2/23

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F 578	Continued From page 5 construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (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. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (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. (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. (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. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on interview and record reviews, it was determined that for two (R8 and R17) out of three residents sampled for advanced directives, the facility failed to offer the opportunity to these	F 578	Corrective Action: " Corrective actions have been ensured by the Director of Nursing. Resident R8 has been provided the opportunity to	

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F 578	Continued From page 6 residents to formulate an advanced directive and document the discussions in each residents' clinical record. Findings include: The facility's admission paperwork, under the Advanced Directives section, documented, "Residents are permitted and encouraged to have an advance health care directive, and any other related documentation recognized by state law, in their file at the Community. If you have executed any advance directives, you must provide a copy to us upon move-in. If you change your advance directive while a resident of the Community, you must provide us with a copy of the new advanced directive. Information on Advance Health Care Directives is attached here." Attached was a 2 page brochure from the DHSS Long Term Care Ombudsman's Office. 12/2016 (last revised) - The facility's policy entitled Advance Directives stated, "... 6. Prior to or upon admission of a resident, the social services director or designee will inquire of the resident, his/her family members and/or his or her legal representative, about the existence of any written advance directives... 8. If the resident indicates that he or she has not established advance directives, the facility staff will offer assistance in establishing advance directives. a. The resident will be given the option to accept or decline the assistance... b. Nursing staff will document in the medical record the offer to assist and the resident's decision to accept or decline assistance... 18. The interdisciplinary team will review annually with the resident his or her advance directives to ensure that such directives are still the wishes of the resident. Such reviews will be made during the annual assessment process and recorded on the resident	F 578	review and complete an Advanced Directive that reflects the resident□s treatment decisions. The care plan for Resident R8 has been updated to include the resident□s desired Advanced Directive decisions. Resident R15 has been provided the opportunity to review and complete an Advanced Directive that reflects the resident□s treatment decisions. The care plan for Resident R15 has been updated to include the resident□s desired Advanced Directive decisions. Identification of Other Residents: " All Residents have the potential to be affected. In order to prevent other residents from being affected, all nursing and social services staff members will be trained on Residents Rights, including the right to make treatment decisions and to have the opportunity to complete an Advanced Directive. A 100% audit of all resident advanced directives has been completed to ensure that each resident has had the opportunity to make treatment decisions regarding their Advanced Directive. Residents without an updated Advanced Directive have been provided an opportunity to do so as a result of this audit, and no remaining concerns regarding Advanced Directives are noted for current residents. System Changes: " The Root Cause of the concern was the failure to accurately adhere to the required elements in the policy Advanced Directives (revised 12.2016). The facility	

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Continued From page 7
assessment instrument (MDS)."

1. R17's clinical record revealed:

11/4/22- Review of the quarterly MDS assessment revealed that R17 was independent in making consistent and reasonable decisions.

Review of R17's clinical record lacked evidence that the resident had an advance directive nor was offered and/or declined the opportunity to formulate an advanced directive with the facility's assistance after she was admitted to the facility on 1/28/22.

1/25/23 at 9:02 AM - During an interview, E21 (SW) confirmed the finding.

2. Review of R8's clinical records revealed the following:

5/10/21- R8 was admitted to the facility.

5/10/21 4:57 PM- An Admission Initial Note by nursing stated that R8 was a DNR (do not resuscitate or perform life saving measures such as CPR), DNI (do not intubate or put in a breathing tube) and DNH (do not hospitalize). COMFORT CARE (keep as comfortable as possible), no tube feeding and no weights. R8 was noted to be confused, but pleasant and easily directed.

5/18/22- A Physician's order was written for AD (advance directive): DNR.

6/29/22 and 8/9/22 Physician notes stated, "... Code Status: DNR/DNI/DNH, comfort care, no tube feeds... Advance Care Planning Details: The

F 578

policy Advanced Directives (revised 12.2016) was reviewed and found to meet professional standards. The Director of Nursing or Designee will complete education for all nursing and social services staff on the requirements for Residents Rights, including the right to make treatment decisions and to have the opportunity to complete an Advanced Directive. The nursing management team will provide oversight to ensure ongoing compliance.

Success Evaluation:
" An audit of a random sample of 10% of resident advanced directives will be completed by the Director of Nursing or Designee to ensure compliance with Residents Rights, including the right to make treatment decisions and to have the opportunity to complete an Advanced Directive; the audits will ensure the presence of an Advanced Directive, the physician order that reflects the treatment choices, and the care plan for the advanced directive; Audits will have a goal of 100% compliance; Audits will be completed weekly until 100% compliance is achieved for 3 consecutive evaluations, then every other week until 100% compliance is achieved for 3 consecutive evaluations, and then monthly until 100% compliance is achieved for 3 consecutive evaluations. Additional audits will be completed as needed based upon the level of compliance. The results of the audits will be reviewed by the Quality Assurance Team.

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F 578	Continued From page 8 patients values and overall goals of future treatment/care were discussed. The patient has the following goals to remain a DNR/do not hospitalize comfort care no tube feeds...". 11/5/22- R8's MDS assessment revealed that she had severe cognitive impairment. Record review lacked a copy of advanced directives for R8. The facility failed to provide R8 or her POA (Power of Attorney) the opportunity to formulate an advance directive and document that it was offered or declined by the resident or her POA. 1/26/23 from 1:20 PM to 2:15 PM- Findings were reviewed during the exit conference with E1 (NHA) E2 (DON) and E19 (Regional Clinical Nurse Specialist).	F 578		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of	F 580		3/2/23

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F 580	Continued From page 9 treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on clinical record review and review of facility documentation, it was determined that for one (R298) out of 14 sampled residents, the facility failed to immediately consult the Physician when R298 experienced a change in condition	F 580	Corrective Action: " Corrective actions have been ensured by the Director of Nursing. The Physician for Resident R298 has been notified regarding the failure of nursing staff to	

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Continued From page 10
after an unwitnessed fall. Findings include:

Review of R298's clinical record revealed:

R298 was admitted to the facility on 11/9/17 with a past medical history including Congestive Heart Failure, Dementia, and a history of falling.

11/7/22 at 12:00 PM- R298 was found lying on the floor face up on her back. The fall was unwitnessed.

11/8/22 at 10:40 AM- A progress note documented, R298 was transferred to the hospital. "Resident sustained fall from bed yesterday. Resident noted with bruise to right lower lip chin area and tongue. Oral cavity assessed, no s/s (signs or symptoms) of active bleeding and/or open areas noted. Resident noted with increased confusion and lethargy. Resident opens eyes with verbal and tactile (touch) stimuli for a few seconds. Resident unable to follow commands. Resident noted to not be able to hold her fork while eating breakfast. [R298's Physician was] in facility at time of assessment and made aware of findings. New order received to transfer resident to ER for eval and treat... EMT arrived at facility to transport resident to Wilmington Hosp ER at 1020."

11/14/22- An incident report documented that E29 (Agency RN) was assigned during the 11 PM to 7 AM shift and noted that R298 slept throughout the shift except for when Neurochecks were performed. E29 stated the resident was alert and oriented to self and able to follow simple commands. E29 also noted that during 6 AM Neurochecks, R298 had brown emesis (vomit) on the left side of the bed and the residents' tongue

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immediately consult the physician regarding a change in condition for Resident #298 on 11/14/22. The resident responsible party has been notified regarding the failure of nursing staff to immediately consult the physician regarding a change in condition for Resident R298 on 11/14/22. A care plan meeting was held for Resident R298 to ensure that the current care plan is up to date, including fall prevention interventions.
Identification of Other Residents:
" All Residents have the potential to be affected. In order to prevent other residents from being affected, all nursing staff members will be educated on the policy for Acute Condition Changes and Physician Notification. A 100% audit of all current residents to identify any significant change in medical condition over the last 14 days and to ensure physician notification has been completed. No new concerns regarding physician notification of changes were identified as a result of this audit.

System Changes:
" The Root Cause of the concern was a failure to follow the policy for Acute Condition Changes □ Clinical Protocol (revised 3.2018) and notify the physician immediately regarding the change in condition for Resident #298. The facility policy for Acute Condition Changes □ Clinical Protocol (revised 3.2018) was reviewed and found to meet professional standards. The facility system for daily clinical review meeting has been updated

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F 580	Continued From page 11 was brown in color. Physician in facility at time of assessment and made aware of findings. The change of status was identified at 6:00 AM and the facility did not consult the Physician until 10:00 AM when the facility got an order to send R298 out. The facility failed to immediately consult the Physician after a change in condition seen after an unwitnessed fall. 1/25/23 at 3:05 PM- E1 (NHA) and E2 (DON) were informed of the findings.	F 580	to include a review of all condition changes to ensure timely physician notification. The Director of Nursing or Designee will complete education for all nursing staff regarding the policy for acute condition changes and physician notification. The nursing management team will provide oversight to ensure ongoing compliance. Success Evaluation: " An initial 100% audit of all changes in medical condition over the last 14 days to ensure physician notification has been completed. Subsequent Audits of a random sample of 10% of residents will be completed by the Director of Nursing or Designee to ensure the completion of physician notification for any change in condition; Audits will have a goal of 100% compliance; Audits will be completed weekly until 100% compliance is achieved for 3 consecutive evaluations, then every other week until 100% compliance is achieved for 3 consecutive evaluations, and then monthly until 100% compliance is achieved for 3 consecutive evaluations. Additional audits will be completed as needed based upon the level of compliance. The results of the audits will be reviewed by the Quality Assurance Team.	
F 646 SS=D	MD/ID Significant Change Notification CFR(s): 483.20(k)(4) §483.20(k)(4) A nursing facility must notify the state mental health authority or state intellectual disability authority, as applicable, promptly after a	F 646		3/2/23

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F 646	Continued From page 12 significant change in the mental or physical condition of a resident who has mental illness or intellectual disability for resident review. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that for one (R14) out of one sampled resident reviewed for PASARR (Preadmission Screening & Resident Review), the facility failed to refer R14 to the appropriate State-designated authority for a Level II PASARR evaluation and determination after R14 was given a new diagnosis and prescribed medication that would require a new PASARR. Findings include: R14's clinical record revealed: R14's PASARR Level I, completed by the hospital on 8/9/19 noted, "Indication of mental illness, mental retardation/related conditions but meets physician's exemption criteria." R14 was admitted to the facility with a diagnosis of anxiety disorder. 6/18/20- R14 was care planned for alterations in mood and behaviors as evidenced by hallucinations, talking into remote due to psychosis. 6/30/20- During a Neurology phone consult, R14 was diagnosed with visual hallucinations and delusions and was prescribed Seroquel, an antipsychotic medication, by E15 (Neurology NP). E15's consult note documented that the former Nursing Director was "Most worried about her hallucinations and delusions. These have been a problem for the past couple of months." 1/25/23 at 9:28 AM- During a combined interview with E1 (NHA), E2 (DON) and E19 (Regional	F 646	Corrective Action: • Corrective actions have been ensured by the Director of Nursing. The PASARR has been updated for Resident R14. Identification of Other Residents: • All Residents have the potential to be affected. In order to prevent other residents from being affected, all nursing and social services staff members will be trained on the requirements for PASARR completion and updates. A 100% audit of all current residents to ensure that the PASARR requirements for completion and updates have been met has been completed to ensure an up-to-date PASARR as needed. No new concerns regarding PASARR completion were noted as a result of this audit. System Changes: • The Root Cause of the concern was a failure to adhere to the facility policy for "Behavioral Assessment, Intervention and Monitoring" (rev. 3.2019) and to update the PASARR as required. The facility policy for "Behavioral Assessment, Intervention and Monitoring" (rev. 3.2019) was reviewed and found to meet professional standards. The facility system for the monthly Behavior Management meeting has been updated to include a discussion of PASARR update needs based on changes in	

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F 646	Continued From page 13 Clinical Nurse Specialist), the Surveyor reviewed the findings and asked if another PASARR evaluation was completed since R14's new psych diagnosis and use of antipsychotic medication on 6/30/20. No further information was received by the Surveyor. 1/26/23 from 1:20 PM to 2:15 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (DON) and E19 (Regional Clinical Nurse Specialist).	F 646	resident status, new psychological diagnoses, or new psychoactive medications. The Director of Nursing or Designee will complete education for all nursing and social services staff regarding the policy for Behavioral Assessment, Intervention and Monitoring and the requirements for PASARR completion and updates. The nursing management team will provide oversight to ensure ongoing compliance. Success Evaluation: • A 100% audit of all current residents to ensure that the PASARR requirements for completion and updates have been met has been completed to ensure an up-to-date PASARR as needed. Subsequent audits of a random sample of a minimum of 5 residents will be completed by the Director of Nursing or Designee to ensure that the PASARR requirements for completion and updates have been met; Audits will have a goal of 100% compliance; Audits will be completed weekly until 100% compliance is achieved for 3 consecutive evaluations, then every other week until 100% compliance is achieved for 3 consecutive evaluations, and then monthly until 100% compliance is achieved for 3 consecutive evaluations. Additional audits will be completed as needed based upon the level of compliance. The results of the audits will be reviewed by the Quality Assurance Team.	
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3)	F 655		3/2/23

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§483.21 Comprehensive Person-Centered Care Planning
§483.21(a) Baseline Care Plans
§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-
(i) Be developed within 48 hours of a resident's admission.
(ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to-
(A) Initial goals based on admission orders.
(B) Physician orders.
(C) Dietary orders.
(D) Therapy services.
(E) Social services.
(F) PASARR recommendation, if applicable.

§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-
(i) Is developed within 48 hours of the resident's admission.
(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).

§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:
(i) The initial goals of the resident.
(ii) A summary of the resident's medications and dietary instructions.

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F 655	Continued From page 15 (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R44) out of one death record reviewed the facility failed to ensure that the baseline care plan was developed within 48 hours of admission and failed to have evidence that the resident/responsible party was provided the baseline care plan summary. Findings include: 10/22/22 - R44 was admitted to the facility. 10/25/22- Care plans were created for R44. 1/24/23 at 2:24 PM - Review of R44's clinical record lacked evidence of a baseline care plan and that a care plan summary was provided to the resident/responsible party. 1/24/23 4:46 PM - During an interview with E2 (DON), E2 confirmed the absence of a baseline care plan for R44. 1/26/23 from 1:20 PM to 2:15 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 and E19 (Regional Clinical Nurse Specialist).	F 655	Corrective Action: • Corrective actions have been ensured by the Director of Nursing. A care plan meeting was held with Resident R44 to ensure that the current care plan is up to date. Identification of Other Residents: • All Residents have the potential to be affected. In order to prevent other residents from being affected, all nursing and social services staff members will be trained on the requirements of the Baseline Care Plan. A 100% audit of all admissions in the last 30 days has been completed to ensure Baseline Care Plan completion. No new concerns regarding Baseline Care Plan completion were noted as a result of this audit. System Changes: • The Root Cause of the concern was a failure to follow the policy for "Care Plans – Baseline" (rev. 5.14.21) and complete a Baseline Care Plan on admission for Resident R44. The facility policy for "Care Plans – Baseline" (rev. 5.14.21) was reviewed and found to meet professional standards. The facility system for daily clinical review meeting has been updated to include a discussion of the Baseline Care Plan meeting schedule for all new	

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F 655	Continued From page 16	F 655	admissions, and interdisciplinary team (IDT) verification of Baseline Care Plan completion for all new admissions in the last 7 days. The Director of Nursing or Designee will complete education for all nursing and social services staff regarding the policy for Baseline Care Plans. The nursing management team will provide oversight to ensure ongoing compliance. Success Evaluation: • A 100% audit of all current residents to ensure that the requirements for Baseline Care Plan completion have been met has been completed. Subsequent audits of all new admissions in the previous 7 days will be completed by the Director of Nursing or Designee to ensure Baseline Care Plan completion; Audits will have a goal of 100% compliance; Audits will be completed weekly until 100% compliance is achieved for 3 consecutive evaluations, then every other week until 100% compliance is achieved for 3 consecutive evaluations, and then monthly until 100% compliance is achieved for 3 consecutive evaluations. Additional audits will be completed as needed based upon the level of compliance. The results of the audits will be reviewed by the Quality Assurance Team.	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be-	F 657		3/2/23

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F 657	Continued From page 17 (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, it was determined that the facility failed to revise the advanced directive care plan for one (R15) out of 14 sampled residents to reflect the current code status order. Findings include: 1. Review of R15's clinical record revealed: 11/7/22- R15's advanced directives care plan listed the following interventions: The resident has an advanced directive(s) and has documentation in their medical record r/t Code status: Full code. The residents wishes will be	F 657	Corrective Action: • Corrective actions have been ensured by the Director of Nursing. A care plan meeting was held with Resident R15 to ensure that the current care plan is up to date. The resident Care Plan was corrected to include an updated plan of care for the resident advanced directive. Identification of Other Residents: • All Residents have the potential to be affected. In order to prevent other residents from being affected, all nursing	

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F 657 Continued From page 18

honored and maintained through the next review date, honor the resident choice for code status, monitor for decline with the resident's health status, and Report findings to the MD.

4/28/22- R15's code status changed from a full code to a Do Not Resuscitate (DNR) and was signed by the Power of Attorney (POA) and the Facility Representative, E21 (SW).

5/5/22- A Physician's DNR code status order was written.

1/24/23 at 2:14 PM- An interview with E21 confirmed findings. E21 stated the facility's Interdisciplinary Team (IDT) was responsible for updating the residents care plan. E21 stated, "Right now we have him as a DNR, but the care plan needs to be updated. Anyone from IDT can update the advanced directives, but I can do it myself. I think I actually put the wrong one in."

Despite R15's updated code status signed by the POA and the Facility Representative (E21) on 4/28/22 and an updated code status order of DNR by the Physician on 5/5/22, the facility failed to revise R15's code status in his care plan. The care plan remained full code until 1/24/23 at 2:14 PM when it was updated by E21 post interview with the Surveyor.

1/26/23 beginning at approximately 1:20 PM- Findings were reviewed with E1 (NHA) AND E2 (DON).

F 657

and social services staff members will be trained on the requirements of the Comprehensive Care Plan, as well as compliance with Care Plan Revisions. A 100% audit of all resident advanced directive care plans has been completed to ensure that each resident has had the opportunity to make treatment decisions regarding their Advanced Directive. The care plans for Residents with Advanced Directives updates have been updated as needed, and no remaining concerns regarding Advanced Directives care plans are noted for current residents. Additional audits will ensure that any other identified Comprehensive Care Plan concerns are corrected.

System Changes:

- The Root Cause of the concern was a failure to follow the policy for “Care Plans, Comprehensive Person-Centered” (rev. 12.2016) and complete, update, and comply with Care Plan revisions requirements for Resident R15. The facility policy for “Care Plans, Comprehensive Person-Centered” (rev. 12.2016) was reviewed and found to meet professional standards. The facility system for the weekly Residents at Risk review meeting has been updated to include a discussion of the Comprehensive Care Plan for all residents admitted within the last 30 days, all residents due for a quarterly or significant change MDS assessment, and other residents identified as at risk, to ensure that the Care Plan is up to date and identified interventions are in place.

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F 657	Continued From page 19	F 657	The Director of Nursing or Designee will complete education for all nursing and social services staff regarding the policy for Comprehensive Care Plans. The nursing management team will provide oversight to ensure ongoing compliance. Success Evaluation: • An initial 100% audit of all resident advanced directive care plans has been completed to ensure that the Care Plan is up to date and that the Advanced Directive care plan has been revised to indicate the resident wishes for their advanced directives. Subsequent audits of a random sample of a minimum of 10% of residents Care Plans will be completed by the Director of Nursing or Designee to ensure that the Care Plan is up to date and that the Advanced Directive care plan has been revised to indicate the resident wishes for their advanced directives; Audits will have a goal of 100% compliance; Audits will be completed weekly until 100% compliance is achieved for 3 consecutive evaluations, then every other week until 100% compliance is achieved for 3 consecutive evaluations, and then monthly until 100% compliance is achieved for 3 consecutive evaluations. Additional audits will be completed as needed based upon the level of compliance. The results of the audits will be reviewed by the Quality Assurance Team	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)	F 677		3/2/23

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F 677	Continued From page 20 §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on resident interview and observation, the facility failed to ensure that one (R15) out of three sampled residents reviewed for Activities of Daily Living (ADLs) received the necessary services to maintain appropriate care for toileting. R15 waited from 9:30 AM to 10:23 AM for incontinence care. Findings include: Review of R15's clinical record revealed: 4/27/21- R15 was admitted to the facility with a past medical history including Chronic Kidney Disease and the need for assistance with incontinence care. 11/7/22- R15's ADL care plan revealed, "The resident requires extensive assist of 1-2 staff for toileting." 1/19/23 at 9:37 AM- During an interview with R15, he stated, "I lay in poo (stool) over an hour many times and the staff says to me... 'We have other people to take care of.' I felt disgusting [it] dries up and cakes up, I have to go through two pants a day because the urine goes through the diaper." 1/24/23 at 10:02 AM- R15 approached the Surveyor in his wheelchair and stated that he had been waiting since 9:30 AM to get changed and he was upset because activities start at 10:30 AM and now he'll miss the music activity. E23 (LPN) approached the Surveyor and R15 and E23	F 677	Corrective Action: • Corrective actions have been ensured by the Director of Nursing. The toileting needs and Care Plan for Resident R15 have been reviewed and updated. The Director of Nursing has met with the resident to discuss the delay in toileting and has encouraged the Resident to notify the Director of Nursing if a similar concern occurs in the future. Education regarding Activities of Daily Living (ADL) assistance and Call Light response has been provided by the Director of Nursing to the nursing staff, who were working at the time this incident occurred, including Employee #23 and Employee #24. Identification of Other Residents: • All Residents have the potential to be affected. In order to prevent other residents from being affected, all nursing staff members will be trained by the Director of Nursing or Designee on the requirements of adequate Activities of Daily Living (ADL) assistance and Call Light response. System Changes: • The Root Cause of the concern was a failure to provide adequate Activities of Daily Living (ADL) assistance and Call Light response to Resident R15. The facility policy for "Activities of Daily Living	

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F 677	Continued From page 21 stated that the CNA was in another room taking care of someone else. E23 walked away from the resident down each hall in search of an available CNA and once unable to find anyone, E23 proceeded with medication administration in the 700 Hall. R15 stated, "They turned off my call light and I am turning it back on I still have poop in my pants!" 1/24/23 at 10:06 AM- R15 turned his call light back on. 1/24/23 10:08 AM- E23 (LPN) was observed by the Surveyor entering R15's room to provide him medication while R15 remained sitting in his wheelchair soiled. 1/24/23 10:12 AM- E23 left R15's room after administering his medication with the call light still on and with the resident still unchanged sitting in his stool. 1/24/23 10:14 AM- R15 wheeled over to the Surveyor and stated, "She (E23) didn't do nothing but spill ginger ale and water all over the place and that's what was taking her so long to clean it up, I am still waiting to be changed." E23 told R15 that the CNA was with another resident right now. 1/24/23 10:23 AM- E24 (CNA) entered R15's room with a sit to stand device. E23 followed behind. 1/24/23 10:34 AM- The Surveyor asked E24 how long it usually takes to receive help with incontinence care. E24 stated, "Not long, if someone is caring for another resident someone will come get you to let you know who is waiting and R15 did not wait long."	F 677	(ADL), Supporting" (3.2018) was reviewed and found to meet professional standards. The facility policy for "Answering the Call Light" (3.2021) was reviewed and found to meet professional standards. The facility system for daily nursing management rounds (see IDT Rounds Form tool) has been updated to include a focus on call light response timeliness to ensure ADL assistance. The nursing management team will provide oversight to ensure ongoing compliance. Success Evaluation: • A Call Light Response audit to ensure proper call light response and ADL assistance will be completed by the Director of Nursing or designee on a random sample of 10% of residents; Audits will have a goal of 100% compliance; Audits will be completed daily until 100% compliance is achieved for 3 consecutive evaluations, then 3 times a week until 100% compliance is achieved for 3 consecutive evaluations, then weekly until 100% compliance is achieved for 3 consecutive evaluations, and then monthly until 100% compliance is achieved for 3 consecutive evaluations. Additional audits will be completed as needed based upon the level of compliance. The results of the audits will be reviewed by the Quality Assurance Team.	

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F 677	Continued From page 22 1/24/23 10:39 AM- Once incontinence care was completed, R15 stated to the Surveyor "It took 1 hour and 15 minutes to be seen with poop on me!" R15 confirmed that this happens often and sometimes he has to wait even longer. The actual time waiting was 53 minutes. 1/26/23 beginning at approximately 1:20 PM- Findings were reviewed with E1 (NHA) AND E2 (DON).	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on policy and record review, observations and interviews, it was determined that for three (R3, R7 and R298) out of 14 sampled residents reviewed for care, the facility failed to ensure that R3, R7 and R298 received care that was consistent with Physician's orders and facility policy. Findings include: 1. Review of R3's clinical record revealed: 2/12/22 - R3 was admitted to the facility with multiple diagnoses, including vascular dementia and muscle atrophy (decreasing size).	F 684	Corrective Action: • Corrective actions have been ensured by the Director of Nursing. A care plan meeting was help for Resident R3 to ensure that the current care plan is up to date. The resident Care Plan was corrected to include an updated plan of care for skin care, including the protective wash cloth under the neck. Resident R7 is no longer a resident in the facility. The Physician for Resident R298 has been notified regarding the incomplete neurological checks for the resident. The	3/2/23

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F 684	Continued From page 23 11/3/2022 - A physician's order was written to insert a washcloth beneath R3's chin for protection every shift. 1/24/23 - A progress note by E20 (NP) stated that R3 keeps her chin against her chest and that R3 has redness and MASD (moisture associated skin damage) on the front of her neck. R3 was observed on 1/20/23 at 8:30 AM, 1/23/23 at 9:20 AM, 1/24/23 at 10:00 AM and 1/26/23 at 8:30 AM without a washcloth under her chin. 1/26/23 8:30 AM - During an interview, E2 (DON) confirmed that a washcloth was not under R3's chin. 2. Review of R7's clinical record revealed: 12/2/22 - R7 was admitted to the facility. 1/12/23 - A progress note by E28 (NP) stated that R7's hearing was reduced and that an exam revealed impacted ear wax in both ears; to start Debrox and will flush ears as needed. 1/12/23 - A physician's order was written for Debrox Solution 6.5% - instill 5 drops in both ears two times a day for excess ear wax for 4 days. Review of R7's Electronic Medical Record (EMR) revealed that R7 did not receive the Debrox Solution from 1/12/23-1/16/23 because the medication was not available from the pharmacy. The Debrox Solution order was automatically discontinued in the EMR on 1/16/23, the order end date.	F 684	resident responsible party for Resident R298 has been notified regarding the incomplete neurological checks for the resident. A care plan meeting was held for Resident R298 to ensure that the current care plan is up to date, including fall prevention interventions. Nursing staff education will be provided to all nursing staff members on the requirements of the Comprehensive Care Plan and compliance with Care Plan Interventions. All nurses will also receive education on post-fall assessment requirements, including neurological checks. Identification of Other Residents: • All Residents have the potential to be affected. In order to prevent other residents from being affected, all nursing and social services staff members will be trained on the requirements of the Comprehensive Care Plan, as well as compliance with Care Plan Interventions. In addition, all nursing staff members will be educated on the policy for Medication and Treatment Orders, actions for Medication Error Prevention, and actions to take if a Medication is Unavailable. A 100% audit of all new medication orders in the last 7 days has been completed to ensure the administration of all medications as prescribed. No new concerns regarding medication administration were noted as a result of this audit. Nurses will also receive education on the policy for Managing Falls and Fall Risk, as well as the policy for Neurological Assessments. A 100% audit of all falls requiring neurological checks in	

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F 684	Continued From page 24 1/23/23 2:00 - During an interview, E2 (DON) confirmed that R7 did not receive the Debrox Solution from 1/12/23-1/16/23 or to date because of a pharmacy delayed medication delivery. 3. Review of R298's clinical record revealed: R298 was admitted to the facility on 11/9/17 with a past medical history including Congestive Heart Failure, Dementia, and a history of falling. 11/7/22 at 12:00 PM- R298 was found lying on the floor face up on her back. The fall was unwitnessed. 11/7/22- Review of the facility's "Neurological Evaluation Flow Sheet" from 12:00 PM - 11:38 PM, after R298's unwitnessed fall, revealed that the facility failed to complete Neurocheck assessments in their entirety post fall. The Glasgow Coma Scale (GCS) total was blank for the entire first day post fall. The GCS total is used to assess for signs of brain injury. Additionally, the "Neurological Evaluation Flow Sheet," also showed that the "Respiratory Pattern" was inconsistently completed. The "Neurological Evaluation Flow Sheet" was completed for 11/8/2022. 1/25/23 at 3:05 PM- E1 (NHA) and E2 (DON) were informed of the findings.	F 684	the last 30 days has been completed to ensure the completion of post-fall assessment requirements, including neurological checks. No new concerns regarding neurological checks completion were noted as a result of this audit. System Changes: • The Root Cause of the concern regarding the wash cloth for Resident R3 was a failure to follow the policy for "Care Plans, Comprehensive Person-Centered" (rev. 12.2016) and complete, update, and comply with Care Plan intervention compliance for Resident. The facility policy for "Care Plans, Comprehensive Person-Centered" (rev. 12.2016) was reviewed and found to meet professional standards. The facility system for daily nursing management rounds (see IDT Rounds Form tool) has been updated to include a focus on ensuring that care planned interventions are present for Residents on the unit. The Director of Nursing or Designee will complete education for all staff regarding the requirements that the Care Plan is up to date and identified interventions are in place. The nursing management team will provide oversight to ensure ongoing compliance. The Root Cause of the concern regarding the physician order for Debrox for Resident R7 was a failure to follow the policy for "Administering Medications" (rev. 4.2019) and to ensure that the prescribed medication for Resident R7 was obtained and administered as prescribed. The facility policy for "Administering Medications"	

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F 684	Continued From page 25	F 684	(rev. 4.2019) was reviewed and found to meet professional standards. The facility policy for “Medication and Treatment Orders” (rev. 7.2016) was reviewed and found to meet professional standards. The facility system for daily clinical review meeting has been updated to include a review of the implementation of all new physician orders to ensure that medications are administered as prescribed. The Director of Nursing or Designee will complete education for all nursing staff regarding the policy for Medication and Treatment Orders, actions for Medication Error Prevention, and actions to take if a Medication is Unavailable. The nursing management team will provide oversight to ensure ongoing compliance. The Root Cause of the concern for Resident the post-fall assessments for Resident R298 was a failure to follow the policy for “Managing Falls and Fall Risk” (rev. 3.2018) and “Neurological Assessments” (rev. 10.2010) to ensure the completion of post-fall assessment requirements, including neurological checks. The facility policy for “Managing Falls and Fall Risk” (rev. 3.2018) was reviewed and found to meet professional standards. The facility policy for “Neurological Assessments” (rev. 10.2010) was reviewed and found to meet professional standards. The facility system for daily clinical review meeting has been updated to include a review of all falls in the last 72 hours to ensure the completion of post-fall assessment requirements, including neurological checks. The Director of Nursing or	

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F 684	Continued From page 26	F 684	Designee will complete education for all nursing staff regarding the policy for Managing Falls and Fall Risk, as well as the policy for Neurological Assessments. The nursing management team will provide oversight to ensure ongoing compliance. Success Evaluation: • In order to ensure ongoing compliance with care plan interventions, such as the wash cloth for R3, an audit of a random sample of a minimum of 5 residents Care Plans will be completed by the Director of Nursing or Designee to ensure that the Care Plan is up to date and identified interventions are in place; Audits will have a goal of 100% compliance; Audits will be completed weekly until 100% compliance is achieved for 3 consecutive evaluations, then every other week until 100% compliance is achieved for 3 consecutive evaluations, and then monthly until 100% compliance is achieved for 3 consecutive evaluations. Additional audits will be completed as needed based upon the level of compliance. The results of the audits will be reviewed by the Quality Assurance Team. In order to ensure ongoing compliance with adhering to physician orders for treatment, an initial 100% audit of all new medication orders in the last 7 days has been completed to ensure the administration of all medications as prescribed. Subsequent Audits of a random sample of a minimum of 5 residents Physician Orders will be completed by the Director of Nursing or	

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F 684	Continued From page 27	F 684	Designee to ensure the administration of all medications as prescribed; Audits will have a goal of 100% compliance; Audits will be completed weekly until 100% compliance is achieved for 3 consecutive evaluations, then every other week until 100% compliance is achieved for 3 consecutive evaluations, and then monthly until 100% compliance is achieved for 3 consecutive evaluations. Additional audits will be completed as needed based upon the level of compliance. The results of the audits will be reviewed by the Quality Assurance Team. In order to ensure ongoing compliance with required post-fall assessments, including neurological assessments, an initial 100% audit of all falls requiring neurological checks in the last 30 days has been completed to ensure the completion of post-fall assessment requirements, including neurological checks. Subsequent Audits of a random sample of all falls in the previous 7 days will be completed by the Director of Nursing or Designee to ensure the completion of post-fall assessment requirements, including neurological checks; Audits will have a goal of 100% compliance; Audits will be completed weekly until 100% compliance is achieved for 3 consecutive evaluations, then every other week until 100% compliance is achieved for 3 consecutive evaluations, and then monthly until 100% compliance is achieved for 3 consecutive evaluations. Additional audits will be completed as needed based upon the level of compliance. The results of the audits will	

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F 684	Continued From page 28	F 684	be reviewed by the Quality Assurance Team.	
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the	F 732		3/2/23

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F 732	Continued From page 29 posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility documentation and staff interviews, it was determined that for five out of six days, the facility failed to ensure that the credentials of staff were written on the posted schedules in the only nurses station. Findings include: 1/25/23 at 2:13 PM- Review of the posted staff schedules from 1/19/23 through 1/25/23 revealed that the facility failed to consistently list the credentials of staff working in the facility. 1/25/23 at 2:17 PM- E2 (DON) confirmed findings. 1/26/23 at 8:19 AM- During an interview with E2, E2 stated the computer was cutting off the staff's credentials if the employee had a long name. E2 subsequently corrected the posted staff schedule for 1/26/23 by writing in the staff's credentials.	F 732	Corrective Action: • Corrective actions have been ensured by the Director of Nursing. The Nurse Staffing Posting is present on the unit and provides the nurse staffing hours; the daily nursing schedule has been updated to include the credentials for all nursing staff. Identification of Other Residents: • All Residents have the potential to be affected. In order to prevent residents from being affected, the nursing management team will ensure that the Nurse Staffing Posting is posted daily and that the nursing schedule includes the credentials of nursing staff members. System Changes: • The Root Cause of the concern was a failure to ensure that the credentials of nursing staff members were present on the daily nursing schedule. The facility system for the daily Nurse Staffing schedule has been updated and now includes the credentials for all nursing staff on the schedule. The facility policy for "Posting Direct Care Daily Staffing Numbers" (7.2016) was reviewed and found to meet professional standards. The Director of Nursing or Designee will complete education for all nursing staff regarding the policy for the daily nurse staffing information posting requirements and the need for the credentials of nursing	

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F 732	Continued From page 30	F 732	staff members on the daily nursing schecule. The nursing management team will provide oversight to ensure ongoing comp iance. Success Evaluation: • A nurse staffing information audit to ensure the proper posting of nurse staffing information, to include nursing staff credentials on the daily schedule, will be completed by the Director of Nursing or designee; Audits will have a goal of 100% compliance; Audits will be completed daily until 100% compliance is achieved for 3 consecutive evaluations, then 3 times a week until 100% compliance is achieved for 3 consecutive evaluations, then weekly until 100% compliance is achieved for 3 consecutive evaluations, and then monthly until 100% compliance is achieved for 3 consecutive evaluations. Additional audits will be completed as needed based upon the level of compliance. The results of the audits will be reviewed by the Quality Assurance Team.	
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any	F 756		3/2/23

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F 756	Continued From page 31 irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record reviews and review of facility documentation, it was determined that for two (R15 and R25) out of five residents reviewed for unnecessary medications, the facility failed to ensure that the Attending Physician reviewed the Medication Regimen Review (MRR) timely. Findings include: Review of R15's clinical record revealed:	F 756	Corrective Action: • Corrective actions have been ensured by the Director of Nursing. The Medication Regimen Review for Resident R15 from 3/5/22 has been provided to the Physician for review and completion. The responsible party has been notified that the previous recommendation was not completed, and that the recommendation	

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1. 3/5/22- A pharmacy consultation report for R15 read, "Comment: [R15] was recently initiated on fexofenadine 180 GIVE 1 TABLET BY MOUTH ONE TIME A DAY FOR RASH FOR 7 DAYS and had an estimated CrCl (Creatinine Clearance) of 50 ml/min (milliliters per minute) on 3/5/22, which may increase the risk of potential adverse events (e.g. [for example], sedation, falls). Recommendation: Please consider reducing the dose of 60 mg (milligrams) once daily. Reducing the dose of fexofenadine/pseudoephedrine 12 hour to one tablet once daily." The MRR lacked evidence that the Attending Physician reviewed or signed the MRR as of 1/25/23.

8/22/22- A pharmacy consultation report for R15 read, "Comment: [R15] has received a combination topical anti-infective/corticosteroid product, lotrisone being applied twice daily for greater then 8 weeks without a documented stop date/ since 6/13/22. Recommendation: Please discontinue lortisone. If therapy cannot be discontinued, please document stop date." The Attending Physician reviewed and signed the MRR on 1/25/23, approximately five months after the recommendation.

2. Review R25's clinical record revealed:

12/14/22- A pharmacy consultation report for R25 read, "Comment: [R25] has a recent order for oseltamivir 75 mg daily for influenza prophylaxis and had had an estimated CrCl of 49 mL/milliliters on 9/21/21. Recommendation: Please reduce dose of oseltamivir to 30mg daily for the remaining treatment period." The Attending Physician reviewed and signed the MRR on 1/25/23, more than a month later.

F 756

has now been provided to the Physician for review. The responsible party has also been notified that the previous recommendation from 8/22/22 was not completed timely, and was completed on 1/25/23. The responsible party for Resident R25 has been notified that the previous Medication Regimen Review recommendations from 12/14/22 and 8/17/22 were not completed timely and were completed on 1/25/23.

Identification of Other Residents:

- All Residents have the potential to be affected. In order to prevent other residents from being affected, all nursing and staff members will be educated on the requirements regarding Medication Regimen Review recommendations. A 100% audit of all pharmacist Medication Regimen Review recommendations for the last 3 months has been completed to ensure adequate follow-up on recommendations, including Physician signature and order implementation. No new concerns regarding Medication Regimen Review pharmacy recommendations completion were noted as a result of this audit.

System Changes:

- The Root Cause of the concern was a failure to adhere to the "Medication Regimen Reviews" (rev. 5.2019) policy and to complete the required follow-up for pharmacist recommendations. The facility policy for "Medication Regimen Reviews" (rev. 5.2019) was reviewed and found to meet professional standards. The facility

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F 756	Continued From page 33 8/17/22- A pharmacy consultation report for R25 read, "Comment: [R25] continues to receive probiotic (microorganisms that are intended to have gut health benefits when consumed) therapy with probiotic, since 4/21. Recommendation: Please consider discontinuation." The Attending Physician authorized the MRR on 1/25/23, approximately five months after the recommendation. 1/26/23 beginning at approximately 1:20 PM- Findings were reviewed with E1 (NHA) AND E2 (DON).	F 756	system for Medication Regimen Reviews has been updated to include a copy of all pharmacist recommendations in the DON office, with a copy of the signed Physician Response and all new orders related to the recommendations to ensure 100% compliance. The Director of Nursing or Designee will complete education for all nursing staff regarding the requirements for Medication Regimen Review recommendations response and completion. The nursing management team will provide oversight to ensure ongoing compliance. Success Evaluation: • An initial 100% audit of all Medication Regimen Review recommendations for the last 3 months has been completed to ensure adequate follow-up on recommendations, including Physician signature and order implementation. Subsequent Audits of a random sample of 10% of the Medication Regimen Review pharmacy recommendations for the previous month will be completed by the Director of Nursing or Designee to ensure adequate follow-up on recommendations, including Physician signature and order implementation; Audits will have a goal of 100% compliance; Audits will be completed weekly until 100% compliance is achieved for 3 consecutive evaluations, then every other week until 100% compliance is achieved for 3 consecutive evaluations, and then monthly until 100% compliance is achieved for 3 consecutive evaluations. Additional audits will be completed as needed based upon the	

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F 756	Continued From page 34	F 756	level of compliance. The results of the audits will be reviewed by the Quality Assurance Team.	
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record reviews, interviews, and review of facility documentation, it was determined that for one (R15) out of five residents sampled for medication review, the facility failed to monitor uric acid levels for a resident on gout medication. Findings include: Review of R15's clinical record revealed:	F 757	Corrective Action: • Corrective actions have been ensured by the Director of Nursing. The uric acid level recommendation for Resident R15 has now been completed. The responsible party has been notified that the previous recommendation was not completed, and that the recommendation	3/2/23

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11/7/22- A Medication Regimen Review for R15 includes, "REPEATED RECOMMENDATION from 8/22/22: Please respond promptly to assure facility compliance with Federal regulations. Please monitor a serum uric acid concentration on the next convenient lab day and every six months. Medications used in management of gout are recommended at doses which maintain a serum uric acid concentration below 6mg/dL."

11/9/22- R15's Physician accepted the recommendation(s) to be implemented as written.

The facility was unable to provide evidence that a Physician's order was submitted and was unable to provide evidence that the labs were completed.

The facility failed to monitor the gout medication for R15 as recommended by the Pharmacist and approved by the Physician.

1/25/23 at 11:40 AM- Findings were confirmed by E19 (Regional Clinical Nurse Specialist) and E2 (DON) was present.

has now been provided to the Physician and new orders completed.

Identification of Other Residents:

- All Residents have the potential to be affected. In order to prevent other residents from being affected, all nursing and staff members will be educated on the requirements regarding resident drug regimens being free from unnecessary medications. An initial 100% audit of all pharmacist Medication Regimen Review recommendations for the last 3 months has been completed to ensure adequate follow-up on recommendations, including Physician signature and order implementation. No new concerns regarding Medication Regimen Review pharmacy recommendations completion were noted as a result of this audit.

System Changes:

- The Root Cause of the concern was a failure to adhere to the "Medication Therapy" (rev. 4.2017) policy which indicates that residents will only receive necessary medications, and the failure to complete the required follow-up for pharmacist recommendations. The facility policy for "Medication Regimen Reviews" (rev. 5.2019) and the policy for "Medication Therapy" (rev. 4.2017) were reviewed and found to meet professional standards. The facility system for Medication Regimen Reviews has been updated to include a copy of all pharmacist recommendations in the DON office, with a copy of the signed Physician Response and all new orders related to

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F 757	Continued From page 36	F 757	the recommendations to ensure 100% compliance. The Director of Nursing or Designee will complete education for all nursing staff regarding the requirement that residents do not receive unnecessary drugs and for Medication Regimen Review recommendations response and completion. The nursing management team will provide oversight to ensure ongoing compliance. Success Evaluation: • An initial 100% audit of all Medication Regimen Review recommendations for the last 3 months has been completed to ensure adequate follow-up on recommendations, including Physician signature and order implementation. • In addition, Unnecessary Medications audits for a random sample of 10% of residents will be completed by the Director of Nursing or Designee to ensure that residents do not receive unnecessary medications; Audits will have a goal of 100% compliance; Audits will be completed weekly until 100% compliance is achieved for 3 consecutive evaluations, then every other week until 100% compliance is achieved for 3 consecutive evaluations, and then monthly until 100% compliance is achieved for 3 consecutive evaluations. Additional audits will be completed as needed based upon the level of compliance. The results of the audits will be reviewed by the Quality Assurance Team.	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)	F 761		3/2/23

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F 761	Continued From page 37 §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation and interview, it was determined that for one (R17) of 28 medication (med) administration opportunities during the med pass, the facility failed to have a current label in accordance with the Physician's order for a med with blood pressure (BP) parameters of when to hold the medication. Findings include: 1/17/23- A physician's order was written for Midodrine HCL (used for low BP by raising the	F 761	Corrective Action: • Corrective actions have been ensured by the Director of Nursing. The medication Drug Label for Resident R17 has been updated by the Pharmacy and is now accurate per the current Physician order. The Physician has been notified that the previous label was incorrect, and that this has now been corrected. The responsible party has been notified that the previous label was incorrect, and that this has now	

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F 761	Continued From page 38 BP) 5 mg give two tablets three times a day and hold for a systolic (top number) BP (SBP) greater than 140. 1/24/23 8:20 AM- E27 (RN Supervisor) obtained R17's BP. 1/24/23 at approximately 8:35 AM- The Surveyor observed the blister pack of Midodrine for R17. The parameter on the label stated to hold for a BP greater than 130/90. When questioned, R27 stated the Physician order in the electronic Medication Administration Record (eMAR) was to hold for the med for a SBP greater than 140. 1/24/23 at approximately 8:40 AM- E27 administered the Midodrine. 1/24/23 9:45 AM- After verifying the eMAR Midodrine order, findings were discussed and confirmed with E27 that the current Midodrine label was incorrect. E27 stated that she'd get a new label. 1/26/23 from 1:20 PM to 2:15 PM- Findings were reviewed during the exit conference with E1 (NHA) E2 (DON) and E19 (Regional Clinical Nurse Specialist).	F 761	been corrected. Identification of Other Residents: • All Residents have the potential to be affected. In order to prevent other residents from being affected, all nursing and staff members will be educated on the requirements regarding medication storage and labeling. A 100% audit of all medication carts for medication storage in order to ensure accurate medication labels for all current residents has been completed. No new concerns regarding medication storage and labeling were noted as a result of this audit. System Changes: • The Root Cause of the concern was a failure to adhere to the "Labeling of Medication Containers" (rev. 4.2019) policy and to ensure that the medication label was accurate based on the current physician order. The facility policy for "Labeling of Medication Containers" (rev. 4.2019) was reviewed and found to meet professional standards. The facility system for daily clinical review meeting has been updated to include a review of all change in medication dosages or administration parameters to ensure that an updated medication label has been obtained and the medication storage and labeling requirements are met. The Director of Nursing or Designee will complete education for all nursing and staff members on the requirements regarding medication storage and labeling. The nursing management team will provide oversight to ensure ongoing	

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F 761	Continued From page 39	F 761	compliance. Success Evaluation: • An initial 100% audit of all medication carts for medication storage in order to ensure accurate medication labels for all current residents has been completed. Subsequent Audits of a random sample of a minimum of 10% of resident medication storage will be completed by the Director of Nursing or Designee to ensure accurate medication labels for all residents; Audits will have a goal of 100% compliance; Audits will be completed weekly until 100% compliance is achieved for 3 consecutive evaluations, then every other week until 100% compliance is achieved for 3 consecutive evaluations, and then monthly until 100% compliance is achieved for 3 consecutive evaluations. Additional audits will be completed as needed based upon the level of compliance. The results of the audits will be reviewed by the Quality Assurance Team.	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent	F 812		3/2/23

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F 812	Continued From page 40 facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and interview, it was determined that the facility failed to ensure that the kitchen was maintained to ensure proper food safety. Findings include: The following were observed during the kitchen tour on 1/19/23 from 8:45 AM to 10:00 AM: - The hand washing sink paper towel dispenser was dispensing too much paper towel causing the clean paper towel to dispense into the hand sink, thus contaminating paper towels; - The light cover in the dry storage room, handwashing station by the dry storage room, and loading bay were in disrepair; - The loading bay door sweep was in disrepair creating gaps for pests. Findings were reviewed and confirmed with E22 (Food Service Director) on 1/19/23 at approximately 10:00 AM.	F 812	Corrective Action: • Corrective actions have been ensured by the Administrator and the Food and Beverage Director. It is the policy of Shipley Living to ensure that food employees clean their hands in a handwashing sink or approved automatic handwashing station and that the handwashing sink is maintained so that it is accessible and sanitary at all times. The paper towel dispenser settings have been adjusted to ensure that the paper towels do not reach the sink itself, and that the amount of paper towel dispensed does not produce the risk of contact between the paper towel and other items or contamination of the paper towels. Repairs have been completed to the light cover in the dry storage room, the handwashing station by the dry storage room, and the loading bay; the loading bay door sweep has been repaired to ensure no gap to allow the possibility of pests. Identification of Other Residents: • All Residents have the potential to be affected. In order to prevent other	

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F 812	Continued From page 41	F 812	residents from being affected, the food and beverage director or designee will ensure that the kitchen handwashing sink is in working order and is maintained so that it is accessible and sanitary at all times, and that the paper towels are not contaminated by contact with the sink or other items. The other areas of the kitchen, including the light cover in the dry storage room, the handwashing station by the dry storage room, and the loading bay will be monitored on daily rounds to ensure good repair and cleanliness. System Changes: • The Root Cause of the concern was a failure to ensure that the kitchen handwashing sink was in working order and good repair while being sanitary at all times, including the paper towels for staff use. In addition, there was a failure to ensure that the light cover in the dry storage room, the handwashing station by the dry storage room, and the loading bay door sweep were maintained in good repair. The facility system for kitchen sanitation rounds has been updated to include weekly rounds with the dietician and food service director to ensure that the handwashing sink is in good repair and working order with no sanitation concerns. The facility policy for "Preventing Foodborne Illness – Employee Hygiene and Sanitary Practices" (rev. 10.2017) and "Handwashing/Hand Hygiene" (rev. 8.2019) were reviewed and found to meet professional standards. The Food and Beverage Director or Designee will	

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F 812	Continued From page 42	F 812	complete education for all dietary staff regarding appropriate standards for kitchen sanitation and hand hygiene, including ensuring that the kitchen handwashing sink is in working order and good repair with proper sanitary standards and all other areas of the kitchen storage and equipment are maintained in good repair. The Food and Beverage Director or Designee will provide oversight to ensure ongoing compliance. Success Evaluation: • A food service sanitation audit to ensure compliance regarding with kitchen sanitation and employee hygiene standards, including the ensuring that the kitchen handwashing sink is in working order and good repair with no sanitation concerns will be completed by the Food and Beverage Director or designee; Audits will have a goal of 100% compliance; Audits will be completed daily until 100% compliance is achieved for 3 consecutive evaluations, then 3 times a week until 100% compliance is achieved for 3 consecutive evaluations, then weekly until 100% compliance is achieved for 3 consecutive evaluations, and then monthly until 100% compliance is achieved for 3 consecutive evaluations. Additional audits will be completed as needed based upon the level of compliance. The results of the audits will be reviewed by the Quality Assurance Team at the monthly Quality Assurance meeting.	
F 868 SS=D	QAA Committee	F 868		3/2/23

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F 868	Continued From page 43 CFR(s): 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c) §483.75(g) Quality assessment and assurance. §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (iv) The infection preventionist. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (i) Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects required under the QAPI program, are necessary. §483.80(c) Infection preventionist participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is not met as evidenced by:	F 868		

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F 868	Continued From page 44 Based on record review and interview, it was determined that the facility failed to have an Infection Preventionist participate on the QAPI (Quality Assurance and Performance Improvement) committee. Additionally, the facility failed to have quarterly QAPI meetings in 2022. Findings include: 1/26/23 - Review of the facility QAPI Team Members list does not include an Infection Preventionist. 1/26/23 - Review of the 2022 quarterly QAPI meeting attendance sheets revealed a missing attendance sheet for quarter two (April, May and June). 1/26/23 - During an interview, E2 (DON) confirmed that the facility did not have a QAPI meeting in quarter two of 2022. 1/26/23 from 1:20 PM to 2:15 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 and E19 (Regional Clinical Nurse Specialist).	F 868	Corrective Action: " Corrective actions have been ensured by the Administrator and the Director of Nursing. The facility Quality Assurance and Performance Improvement (QAPI) committee now includes a full-time Infection Preventionist who participates in QAPI meetings. QAPI meetings have resumed in the facility, and the most recent QAPI meeting was held on 1/18/23 to review QAPI data for the fourth quarter of 2022. Moving forward, QAPI meetings will occur regularly and at a minimum, quarterly; all QAPI meetings will include the Infection Preventionist. Identification of Other Residents: " All Residents have the potential to be affected. In order to prevent other residents from being affected, the facility Quality Assurance and Performance Improvement (QAPI) committee will meet monthly moving forward and will maintain a QAPI binder with active Performance Improvement Plans and outcomes. A review of the Facility QAPI plan has been completed, and an initial Plan of Correction has been developed in response to the Annual Health Department Recertification Survey. System Changes: " The Root Cause of the concern was a failure to adhere to the facility policy for Quality Assurance and Performance Improvement (QAPI) Program (rev. 2.2020). The facility policy for Quality Assurance and Performance Improvement (QAPI) Program (rev.	

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F 868	Continued From page 45	F 868	2.2020) was reviewed and found to meet professional standards. The facility system for managing the QAPI Program has been updated and the facility Quality Assurance and Performance Improvement (QAPI) committee will meet monthly moving forward and will maintain a QAPI binder with active Performance Improvement Plans and outcomes. The administrator and the nursing management team will provide oversight to ensure ongoing compliance. Success Evaluation: " A QAPI Program audit to ensure compliance with QAPI requirements will be completed by the Director of Nursing or designee; Audits will have a goal of 100% compliance; Audits will be completed weekly until 100% compliance is achieved for 3 consecutive evaluations, then every other week until 100% compliance is achieved for 3 consecutive evaluations, and then monthly until 100% compliance is achieved for 3 consecutive evaluations. Additional audits will be completed as needed based upon the level of compliance. The results of the audits will be reviewed by the Quality Assurance Team.	
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the	F 880		3/2/23

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F 880	Continued From page 46 development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.	F 880		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 47 (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and review of the clinical record and facility documentation as indicated, the facility failed to have an effective Infection Prevention and Control Program surveillance system that identified, tracked, monitored and/or reported infections from January 1, 2022 through April 30, 2022. In addition, the facility's surveillance system for the subsequent months were incomplete with missing data and lacked evidence of an ongoing analysis of the data and documentation of follow-up activity. Findings include: Cross refer F882 Sept. 2017 last revised - The facility's policy entitled "Surveillance for Infections" stated, "The	F 880	Corrective Action: • Corrective actions have been ensured by the Director of Nursing. The nursing management team has been educated regarding the requirements of infection surveillance. The required Infection Control surveillance data has been updated. The Infection Preventionist monitors all infections for trends and significant organisms, as well as antibiotic utilization to ensure antibiotic stewardship. The data for October 2022 has been corrected to reflect the treatment for fungal dermatitis for Resident R34. Identification of Other Residents: • All Residents have the potential to be	

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F 880 Continued From page 48

infection preventionist will conduct ongoing surveillance for healthcare-associated infections and other... significant infections that have substantial impact on potential resident outcome and that may require transmission-based precautions and other preventative interventions... Gathering Surveillance Data 1. The infection preventionist... is responsible for gathering and interpreting surveillance data. The infection control committee and/or QAPI (Quality Assurance Performance Improvement) committee may be involved in interpretation of the data... Interpreting Surveillance Data 1. Analyze the data to identify trends...".

From January 1, 2022 through April 30, 2022, the facility lacked evidence of any infection control surveillance data, analysis and follow-up documentation.

May 2022 - The facility implemented a new Infection Control software tool to assist in tracking facility infections through an Infection Control Data Log, which included, but was not limited to, data collection of the identified pathogens, antibiotic therapy ordered, infections that are reportable to the State, and calculated infection rates.

Review of the monthly Infection Control Data Logs from May 2022 through December 2022 revealed missing data, including the identified pathogens, and lack of evidence of monthly infection rates, analysis and recommendations. An example of missing data on the October 2022 Infection Control Data Log included that the facility failed to capture R34's treatment of fungal dermatitis for four days (10/6/22 through 10/9/22).

F 880

affected. In order to prevent other residents from being affected, the facility has completed a 100% audit of all current resident infections and antibiotic orders to ensure proper infection and antibiotic tracking and surveillance.

System Changes:

• The Root Cause of the concern was a failure to adhere to the facility policy for "Infection Prevention and Control Program" (rev. 10.2018) and the facility policy for "Surveillance for Infections" (rev. 9.2017). The facility policy for "Infection Prevention and Control Program" (rev. 10.2018) and the facility policy for "Surveillance for Infections" (rev. 9.2017) were reviewed and found to meet professional standards. The facility system for managing the Infection Prevention and Control Program has been updated to include a monthly review of compliance with Surveillance for Infections in the monthly Quality Assurance and Performance Improvement (QAPI) committee meeting. The nursing management team will provide oversight to ensure ongoing compliance.

Success Evaluation:

• An initial 100% audit of all current resident infections and antibiotic orders to ensure proper infection and antibiotic tracking and surveillance has been completed. Subsequent Audits of the Infection Prevention and Control Program and the Surveillance of Infections to ensure compliance with infection control

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F 880	Continued From page 49 1/25/23 at 10:45 AM - During a combined interview, E4 (IP) and E31 (Foulk Living ADON) confirmed the findings. 1/26/23 from 1:20 PM to 2:15 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (DON) and E19 (Regional Clinical Nurse Specialist).	F 880	program and infection surveillance requirements will be completed by the Director of Nursing or designee; Audits will have a goal of 100% compliance; Audits will be completed weekly until 100% compliance is achieved for 3 consecutive evaluations, then every other week until 100% compliance is achieved for 3 consecutive evaluations, and then monthly until 100% compliance is achieved for 3 consecutive evaluations. Additional audits will be completed as needed based upon the level of compliance. The results of the audits will be reviewed by the Quality Assurance Team.	
F 881 SS=F	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on interview and review of facility documentation, the facility failed to have an ongoing facility-wide antibiotic stewardship program from January 2022 through December 2022. Findings include: Cross refer to F880, F882	F 881	Corrective Action: • Corrective actions have been ensured by the Director of Nursing. The nursing management team has been educated regarding the requirements of antibiotic stewardship. The required Infection Control surveillance data has been updated to ensure review of antibiotic	3/2/23

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12/2016 last revised - The facility's policy entitled "Antibiotic Stewardship - Review and Surveillance of Antibiotic Use and Outcomes" stated, "... As part of the facility antibiotic stewardship program, all clinical infections treated with antibiotics will undergo review by the infection preventionist (IP), or designee... identify specific situations that are not consistent with the appropriate use of antibiotics... 4. All resident antibiotic regimens will be documented on the facility-approved antibiotic surveillance tracking form...".

12/2016 last revised - The facility's policy entitled "Antibiotic Stewardship - Staff and Clinician Training and Roles" stated, "... The IP will monitor over time and report to the IPCC (Infection Prevention and Control Committee): a. measures of antibiotic use... b. antibiotic susceptibility patterns... c. negative outcomes or events related to antibiotic use, for example: (1) C. difficile infections; (2) adverse drug events; and (3) antibiotic resistance rates...".

1/25/23 at 10:45 AM - During a combined interview, E4 (IP) and E31 (Foulk Living ADON) confirmed the finding. The facility lacked evidence of an ongoing antibiotic stewardship program from January 2022 through December 2022.

1/26/23 from 1:20 PM to 2:15 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (DON) and E19 (Regional Clinical Nurse Specialist).

F 881

utilization. The Infection Preventionist monitors all antibiotic utilization to ensure antibiotic stewardship.

Identification of Other Residents:
• All Residents have the potential to be affected. In order to prevent other residents from being affected, the facility has completed a 100% audit of all current resident antibiotic orders to ensure proper antibiotic utilization and stewardship.

System Changes:
• The Root Cause of the concern was a failure to adhere to the facility policy for "Infection Prevention and Control Program" (rev. 10.2018) and the facility policy for "Antibiotic Stewardship – Review and Surveillance of Antibiotic Use and Outcomes" (rev. 12.2016). The facility policy for "Infection Prevention and Control Program" (rev. 10.2018) and the facility policy for "Antibiotic Stewardship – Review and Surveillance of Antibiotic Use and Outcomes" (rev. 12.2016) were reviewed and found to meet professional standards. The facility system for managing the Infection Prevention and Control Program has been updated to include a monthly review of compliance with Antibiotic utilization tracking and Antibiotic stewardship review in the monthly Quality Assurance and Performance Improvement (QAPI) committee meeting. The nursing management team will provide oversight to ensure ongoing compliance.

Success Evaluation:

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F 881	Continued From page 51	F 881	• An initial 100% audit of all current resident infections and antibiotic orders to ensure proper antibiotic utilization and stewardship has been completed. Subsequent Audits of the Infection Prevention and Control Program and the monitoring of antibiotic utilization to ensure compliance with infection control program and antibiotic stewardship requirements will be completed by the Director of Nursing or designee; Audits will have a goal of 100% compliance; Audits will be completed weekly until 100% compliance is achieved for 3 consecutive evaluations, then every other week until 100% compliance is achieved for 3 consecutive evaluations, and then monthly until 100% compliance is achieved for 3 consecutive evaluations. Additional audits will be completed as needed based upon the level of compliance. The results of the audits will be reviewed by the Quality Assurance Team.	
F 882 SS=E	Infection Preventionist Qualifications/Role CFR(s): 483.80(b)(1)-(4) §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP) (s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training,	F 882		3/2/23

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experience or certification;

§483.80(b)(3) Work at least part-time at the facility; and

§483.80(b)(4) Have completed specialized training in infection prevention and control.
This REQUIREMENT is not met as evidenced by:
Based on interview and review of facility documentation as indicated, it was determined that the facility failed to have an Infection Preventionist (IP) responsible for the facility's IPCP (Infection Prevention and Control Program) that had completed specialized training in infection prevention and control from 9/1/22 to 1/3/23, approximately 4 months. Findings include:

1/19/23 - In response to documentation requests during the Survey's Entrance Conference, the facility provided evidence of specialized infection prevention and control training of E4, who was hired on 1/4/23 as the facility's IP.

1/25/23 at 1:15 PM - During an interview, E2 (DON) stated that she took over the IP role after E30 (former DON) left the facility on 8/31/22. E2 confirmed that she did not have specialized training in infection prevention and control.

1/26/23 from 1:20 PM to 2:15 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 and E19 (Regional Clinical Nurse Specialist).

F 882

Corrective Action:
" Corrective actions have been ensured by the Director of Nursing. Due to the recognized need for a qualified Infection Preventionist and Employee E2 (DON) not having the required specialized infection control training, the facility hired a new employee (Employee E4) as a qualified Infection Preventionist on 1/4/23, who now oversees the Infection Prevention and Control Program and completes infection surveillance and monitors all antibiotic utilization to ensure antibiotic stewardship.

Identification of Other Residents:
" All Residents have the potential to be affected. In order to prevent other residents from being affected, the facility has completed a 100% audit of all current resident antibiotic orders to ensure proper infection surveillance and antibiotic utilization and stewardship. To prevent any residents from being affected by a recurrence in the future, the facility will ensure at each monthly QAPI review that a qualified Infection Preventionist is on staff, and will develop a quality assurance plan as needed to address any Infection Preventionist needs.

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F 882	Continued From page 53	F 882	System Changes: " The Root Cause of the concern was a failure to adhere to the facility policy for Infection Preventionist (rev. 7.2016) by not having a qualified Infection Preventionist on staff. The facility system for managing the Infection Preventionist requirement has been updated to include a monthly quality assurance review of compliance with the requirement to have a qualified Infection Preventionist on staff who oversees the Infection Prevention and Control Program. If the monthly quality assurance review reveals any concern with qualified Infection Preventionist coverage, a quality assurance plan will be implemented, and another licensed nurse will immediately complete Infection Preventionist training with the Centers for Disease Control. The facility policy for Infection Preventionist (rev. 7.2016) were reviewed and found to meet professional standards. The nursing management team will provide oversight to ensure ongoing compliance. Success Evaluation: " An Audit of the Infection Prevention and Control Program, including the requirement to verify that the facility has a qualified Infection Preventionist with specialized infection prevention and control training to oversee the Infection Prevention and Control Program, will be completed by the Director of Nursing or designee; Audits will have a goal of 100% compliance; Audits will be completed weekly until 100% compliance is achieved for 3 consecutive evaluations, then every	

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F 882	Continued From page 54	F 882	other week until 100% compliance is achieved for 3 consecutive evaluations, and then monthly until 100% compliance is achieved for 3 consecutive evaluations. Additional audits will be completed as needed based upon the level of compliance. The results of the audits will be reviewed by the Quality Assurance Team.	
F 885 SS=E	Reporting-Residents,Representatives&Families CFR(s): 483.80(g)(3)(i)-(iii) §483.80(g) COVID-19 reporting. The facility must— §483.80(g)(3) Inform residents, their representatives, and families of those residing in facilities by 5 p.m. the next calendar day following the occurrence of either a single confirmed infection of COVID-19, or three or more residents or staff with new-onset of respiratory symptoms occurring within 72 hours of each other. This information must— (i) Not include personally identifiable information; (ii) Include information on mitigating actions implemented to prevent or reduce the risk of transmission, including if normal operations of the facility will be altered; and (iii) Include any cumulative updates for residents, their representatives, and families at least weekly or by 5 p.m. the next calendar day following the subsequent occurrence of either: each time a confirmed infection of COVID-19 is identified, or whenever three or more residents or staff with new onset of respiratory symptoms occur within 72 hours of each other. This REQUIREMENT is not met as evidenced	F 885		3/2/23

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F 885	Continued From page 55 by: Based on interview and review of facility documentation, it was determined that the facility failed to inform residents, their representatives, and families after infections of COVID-19 of one resident on 1/1/23 and one staff member on 1/16/23 by 5:00 PM the next calendar day. Findings include: 1/19/23 - In response to the Survey's Entrance Conference request for facility documentation, the facility provided a handwritten response that stated: "The facility's mechanism use to inform residents, their representatives and families of confirmed or suspected COVID-19 activity in the facility is via (by) email." Review of the facility's line listing for the past four weeks revealed: -1/1/23, one resident tested positive for COVID-19; and -1/16/23, one staff person tested positive for COVID-19. The facility lacked evidence that residents, their representatives, and families were informed by 5:00 PM the next calendar day by email after each positive COVID-19 individual. 1/25/23 at 10:45 AM - During a combined interview, E4 (IP) and E31 (Foulk Living ADON) confirmed the finding. 1/26/23 from 1:20 PM to 2:15 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (DON) and E19 (Regional Clinical Nurse Specialist).	F 885	Corrective Action: • Corrective actions have been ensured by the Director of Nursing. The nursing management team has been educated regarding the requirements of COVID-19 reporting to residents, families, and staff. The facility hired an Infection Preventionist on 1/4/23 who oversees the Infection Prevention and Control Program and will work with the Director of Nursing to ensure that Residents and families are kept informed of the current COVID-19 situation in the facility. Communication has been provided to Residents and to their Representatives/Families informing them of the facility failure to notify them of a COVID-19 positive resident on 1/1/23 and of a COVID-19 positive staff member on 1/16/23. Identification of Other Residents: • All Residents have the potential to be affected. In order to prevent other residents from being affected, the facility has updated the system for staff, resident, and family notification regarding COVID-19 infections, to include a review during the daily clinical review meeting of all new COVID-19 infections and Interdisciplinary Team (IDT) verification that communication has been provided to residents, families, and staff. System Changes: • The Root Cause of the concern was a failure to adhere to the facility policy for "Coronavirus Disease (COVID-19) – Reporting Facility Data to Residents and	

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F 885	Continued From page 56	F 885	Families" (rev. 5.2020). The facility policy for "Coronavirus Disease (COVID-19) – Reporting Facility Data to Residents and Families" (rev. 5.2020) was reviewed and found to meet professional standards. The facility system for staff, resident, and family notification regarding COVID-19 infections, has been updated to include a review during the daily clinical review meeting of all new COVID-19 infections and Interdisciplinary Team (IDT) verification that communication has been provided to residents, families, and staff. The facility system for managing the Infection Prevention and Control Program has been updated to include a monthly review of compliance with the staff, resident, and family notification regarding COVID-19 infections in the monthly Quality Assurance and Performance Improvement (QAPI) committee meeting. The nursing management team will provide oversight to ensure ongoing compliance. Success Evaluation: • Audits of the COVID-19 Testing and Reporting process to ensure compliance with the reporting of COVID-19 infections to residents, families, and staff will be completed by the Director of Nursing or designee; Audits will have a goal of 100% compliance; Audits will be completed weekly until 100% compliance is achieved for 3 consecutive evaluations, then every other week until 100% compliance is achieved for 3 consecutive evaluations, and then monthly until 100% compliance is achieved for 3 consecutive evaluations.	

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F 885	Continued From page 57	F 885	Additional audits will be completed as needed based upon the level of compliance. The results of the audits will be reviewed by the Quality Assurance Team.	
F 886 SS=F	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that	F 886		3/2/23

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F 886	Continued From page 58 is consistent with current standards of practice for conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by: Based on interview and review of facility and State of Delaware's Department of Public Health (DPH) documentation, it was determined that the facility failed to conduct COVID-19 testing of staff and residents in response to a positive resident on 1/1/23 and a positive staff member on 1/16/23 according to the State of Delaware COVID-19 infection guidance. Findings includes:	F 886	Corrective Action: • Corrective actions have been ensured by the Director of Nursing. The nursing management team has been educated regarding the requirements of COVID-19 testing for residents and staff. The facility hired an Infection Preventionist on 1/4/23 who oversees the Infection Prevention	

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F 886	Continued From page 59 1/3/23 at 6:20 AM - Based on the facility reporting a COVID-19 positive resident, an email was sent to E2 (DON) from the State of Delaware's DPH that outlined recommended general guidance that included testing of residents/staff. 1/17/23 at 1:40 PM - Based on the facility's reporting of a COVID-19 positive staff member, an email was sent to E25 (HR Director) from the State of Delaware's DPH that outlined recommended general guidance that included testing of residents/staff. 1/25/23 at 10:45 AM - During a combined interview with E4 (IP), E31 (Foulk Living ADON) and E2 (DON), E2 (DON) stated that during the first outbreak on 1/1/23, the facility conducted focused-testing of staff as the resident never left the room. The Surveyor asked to review the documentation of staff testing and no documentation was provided. There was no evidence of focused outbreak testing of staff completed on Day 1, Day 3, Day 5, and Day 8-14. During the second outbreak when a staff member tested COVID-19 positive on 1/16/23, the facility conducted broad-based testing of staff/residents on Day 1 and provided the Surveyor with testing evidence. However, the facility lacked evidence of broad-based testing of staff/residents on Day 3 and Day 5. Two additional residents tested COVID-19 positive on 1/23/22 and broad-based testing of staff/residents was conducted on 1/24/23, which covered the Day 8-14 testing requirement from the second outbreak. E4 and E31 confirmed the findings.	F 886	and Control Program and will work with the Director of Nursing to ensure that all COVID-19 testing for Residents and staff are completed as required. Communication has been provided to Residents and to their Representatives/Families informing them of the facility failure to complete required testing in response to a COVID-19 positive resident on 1/1/23 and a COVID-19 positive staff member on 1/16/23. Identification of Other Residents: • All Residents have the potential to be affected. In order to prevent other residents from being affected, the facility has updated the system for the testing of Residents and staff for COVID-19 infections, to include a review during the daily clinical review meeting of all new COVID-19 symptoms and infections, and Interdisciplinary Team (IDT) verification that all required testing has been completed. System Changes: • The Root Cause of the concern was a failure to adhere to the facility policy for "Coronavirus Disease (COVID-19) – Testing Residents" (rev. 9.2021) and "Coronavirus Disease (COVID-19) – Testing Staff" (9.2021). The facility policy for "Coronavirus Disease (COVID-19) – Testing Residents" (rev. 9.2021) and "Coronavirus Disease (COVID-19) – Testing Staff" (rev. 9.2021) were reviewed and found to meet professional standards. The facility system for the testing of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085031	A. BUILDING ______ B. WING ______	C 01/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHIPLEY LIVING	**2723 SHIFLEY ROAD** **WILMINGTON, DE 19810**

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F 886	Continued From page 60	F 886	Residents and staff for COVID-19 infections has been updated to include a review during the daily clinical review meeting of all new COVID-19 symptoms and infections, and Interdisciplinary Team (IDT) verification that all required testing has been completed. The facility system for managing the Infection Prevention and Control Program has been updated to include a monthly review of compliance with the testing of Residents and staff for COVID-19 infections as required in the monthly Quality Assurance and Performance Improvement (QAPI) committee meeting. The nursing management team will provide oversight to ensure ongoing compliance. Success Evaluation: • Audits of the COVID-19 Testing and Reporting process to ensure compliance with the testing of Residents and staff for COVID-19 infections will be completed by the Director of Nursing or designee; Audits will have a goal of 100% compliance; Audits will be completed weekly until 100% compliance is achieved for 3 consecutive evaluations, then every other week until 100% compliance is achieved for 3 consecutive evaluations, and then monthly until 100% compliance is achieved for 3 consecutive evaluations. Additional audits will be completed as needed based upon the level of compliance. The results of the audits will be reviewed by the Quality Assurance Team.	
F 943 SS=D	Abuse, Neglect, and Exploitation Training	F 943		3/2/23

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F 943	Continued From page 61 CFR(s): 483.95(c)(1)-(3) §483.95(c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- §483.95(c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. §483.95(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property §483.95(c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on interview and review of facility documentation, it was determined that the facility failed to ensure that required training for abuse, neglect, and exploitation training was completed for one (E26) out of 10 randomly sampled staff members. Findings include: Review of E26's personnel records revealed: 3/14/19- E26 worked her first assignment in the facility. 4/23/20- E26's Abuse, Neglect, and Exploitation Training was completed. 1/20/23- E25 (HR Director) completed the Staff Training and Vaccination packet, however, annual Abuse, Neglect, and Exploitation Training documentation was outstanding for E26. It was	F 943	Corrective Action: • Corrective actions have been ensured by the Administrator and the Director of Nursing. The required Abuse training has been completed by Employee E26. Identification of Other Residents: • All Residents have the potential to be affected. In order to prevent other residents from being affected, the facility has completed a 100% audit of all current employees to ensure that all training requirements have been completed, including abuse prevention training. System Changes: • The Root Cause of the concern was a failure to adhere to the facility policy for "Staff Development Program" (rev.	

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F 943	Continued From page 62 last completed on 4/23/20. 1/25/23 at 3:05 PM- E2 (DON) and E1 (NHA) confirmed findings. 1/26/23 at 8:22 AM- Documents that were left for the Surveyor revealed updated Abuse, Neglect, and Exploitation Training for E26. The training was signed and dated 1/23/23 by E26, after E25 completed the initial Staff Training and Vaccination packet and was provided the random selection of employees. E26 was due for her annual abuse training since 4/23/21 and was not provided the annual Abuse training until 1/23/23 during the facility's survey.	F 943	5.2019). The facility policy for "Staff Development Program" (rev. 5.2019) was reviewed and found to meet professional standards. The facility system for managing the Staff Development Program has been updated to include a monthly review of compliance in the monthly Quality Assurance and Performance Improvement (QAPI) committee meeting. The administrator and the nursing management team will provide oversight to ensure ongoing compliance. Success Evaluation: • A Staff Development Program audit to ensure compliance with staff training requirements will be completed by the Director of Nursing or designee; Audits will have a goal of 100% compliance; Audits will be completed weekly until 100% compliance is achieved for 3 consecutive evaluations, then every other week until 100% compliance is achieved for 3 consecutive evaluations, and then monthly until 100% compliance is achieved for 3 consecutive evaluations. Additional audits will be completed as needed based upon the level of compliance. The results of the audits will be reviewed by the Quality Assurance Team.	